MARICOPA INTEGRATED HEALTH SYSTEM

Count on us to care.

Publishing dates:
July 19 and July 26, 2001

REVIEW OF QUALIFICATIONS

DENTAL AND/OR ORAL MAXILLOFACIAL SURGERY SERVICES

Released: July 20, 2001

Deadline for Inquiries	Open
Time and Date Responses Due	Open and Continuous

SOLICITATION NUMBER 60-02-003 ROQ

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MARICOPA INTEGRATED HEALTH SYSTEM

Count on us to care.

NOTICE OF SOLICITATION

60-02-003-RFQ

REVIEW OF QUALIFICATIONS: **DENTAL and/or ORAL MAXILLOFACIAL SURGERY SERVICES**

Maricopa County dba: Maricopa Integrated Health System is conducting an open and continuous Review of Qualifications for Dental and/or Oral Maxillofacial Surgery Services. MIHS hereby solicits responses from qualified Arizona licensed dentists to provide services in their private offices to Maricopa Integrated Health Systems – Health Plan (MIHS-HP) members. Services to be provided must be comprehensive, including: 1) Preventive/hygiene services, 2) Periodontics, 3) Operative dentistry 4) Endodontics, 5) Prosthodontics and 6) Pediatric Dentistry. There is special emphasis on the need for providers in the Aguila, Apache Junction, Arlington, Buckeye, Carefree, Cave Creek, Chandler, El Mirage, Fountain Hills, Gila Bend, Gilbert, Goodyear, Mesa, Paradise Valley, Peoria, Queen Creek, Scottsdale, Sun Cities, Surprise, Tempe, Tonopah, Youngtown and Wickenburg areas.

Review of Qualifications packages may be obtained after 1:00 p.m., Friday, July 20, 2001 at:

Maricopa Integrated Health System
Contracts Management
2611 East Pierce, 2nd Floor
Phoenix, Arizona 85008

Written questions concerning this Review of Qualifications package should be addressed to Brian Maness at Maricopa Integrated Health System, 2611 East Pierce Street, 2nd Floor, Phoenix, Arizona 85008.

Submit one (1) original and one (1) copy of the following documentation for each Dentist/Oral Maxillofacial Surgeon. Completed and sealed responses received by MIHS Contracts Management, 2611 E. Pierce, 2nd Floor, Phoenix, Arizona 85008 no later than 2:00 p.m., Friday, August 3, 2001 will be evaluated in the first round of considered responses.

- Table of Contents
- Authorization to Submit Response and Required Certifications (Attachment E)*
- Two (2) Letters of Reference (Do not include references from partners) (Attachment F)*
- Professional Qualifications:
  - Arizona Dental License
  - ADA Board Certification
  - DEA License
  - Curriculum Vitae
  - List of Hospital Privileges, if applicable
- Description of sanctions placed by any licensing or credentialing body, and most recent deficiency reports
- List of office locations, phone numbers, and business hours (Attachment G)*
- Signed Price Acceptance Sheet (Attachment H)*
- Completed Provider Information Form (Attachment I)*
- Signed Authorization/Release Form (Attachment J)*

- Signed Addenda Cover Page(s) to this ROQ (if applicable). Only 1 original required
- Respondent's Checklist (Attachment K)*

*Available in the Review of Qualifications Packet

Selected qualified applicants are required to successfully complete MIHS' full credentialing process and agree to comply with all insurance and regulatory requirements, Quality Management and Utilization Management programs.

This solicitation will remain open and continuous until such time as an adequate number of Dental and/or Oral Maxillofacial Surgeon Services providers are acquired to meet the needs of the MIHS-HP members located throughout the County.

This announcement does not commit Maricopa County to award a contract or to pay any costs incurred in the preparation of Responses. Maricopa County reserves the right to accept or reject, in whole or in part, all responses submitted and/or to cancel this announcement. The contracts are scheduled for award upon successful completion of the credentialing process and approval by the Board of Supervisors or Chief Procurement Officer for an initial two (2) year term with an option to extend for up to 3 additional annual periods. The Maricopa County Procurement Code ("The Code") governs this procurement and is incorporated by this reference.

INQUIRIES/SOLICITATION REQUESTS

Brian Maness
Telephone: (602) 344-1430
Fax: (602) 344-1813
Email: Brian.Maness@hcs.maricopa.gov

THIS REVIEW OF QUALIFICATIONS REPLACES SOLICITATION NUMBER 60-01-028-ROQ ADVERTISED ON FEBRUARY 10 AND 17, 2000.

1.0 EXECUTIVE SUMMARY

This service provides professional Dental and/or Oral Maxillofacial Surgery Services to participating Maricopa Integrated Health System-Health Plan members. The Respondent may choose to submit a response for either Dental or Oral Maxillofacial Surgery or both services. In addition, this service provides professional management of dental health and prevention for Early Prevention and Screening, Diagnosis and Treatment Services (EPSDT) for AHCCCS eligible children from birth to twenty-one years of age as required.

Members from all four MIHS health plans are eligible to receive these services. The health plans are: Maricopa Health Plan (an AHCCCS acute care plan), Maricopa Long Term Care Plan (an AHCCCS long term care plan), and Maricopa Senior Select Plan (a Medicare + Choice plan The total health plan membership is approximately 48,286.

The Respondent must successfully complete the MIHS credentialing process prior to award of a contract.

This solicitation contains a complete copy of an MIHS contract for review, all forms necessary for submission and health plan evidence of coverage.

2.0 SCHEDULE OF EVENTS

The time frame for the procurement under this ROQ is as follows:

Notice of Solicitation	July 19 and 26, 2001
Review of Qualifications released	1:00 p.m., July 20, 2001
Deadline for Written Questions	12:00 p.m. (noon), July 27, 2001
Initial Submission Deadline*	2:00 p.m. August 3, 2001
MIHS Submission Review for initial evaluation	August 6, 2001
Credentialing Process Complete	To Be Determined
Contract Negotiations Finalized	To Be Determined
Contract Start Date	To Be Determined

* Submissions received after this date will be periodically reviewed until such time as a sufficient number of contractors have been found.

Maricopa County reserves the right to deviate from this schedule. If any deviation becomes necessary, all parties on record as accepting a Review of Qualifications package will be notified in writing in an Addendum to this ROQ. Answers to the written questions submitted by Respondents concerning the ROQ will be provided to all parties in the form of an Addendum. Inquiries may be submitted by telephone, but must be followed up in writing. No oral communication is binding on MIHS.

SECTION III WORK STATEMENT
DENTAL SERVICES

3.0 WORK STATEMENT – DENTAL SERVICES

1. SERVICE GOAL

The goal of this service is to provide high quality, cost effective dental service to eligible MIHS-HP members. This service provides professional dental services to Maricopa Integrated Health System – Health Plans' (MIHS-HP) members. In addition, this service provides professional management of dental health and prevention for Early Prevention and Screening, Diagnosis and Treatment Services (EPSDT) for AHCCCS eligible children from birth to twenty-one (21) years of age as required. Service availability and member acceptability are determined by the individual health or dental plan in which the member is enrolled.

2. UNIT OF SERVICE

One (1) unit of service equals one (1) diagnostic procedure, and/or one (1) treatment procedure and/or one (1) laboratory, pre-operative, or post-operative procedure; and/or one complete fabrication of dentures (either full or partial) to include x-rays, molds, models, and construction as well as any or all additional fittings.

3. SERVICE OBJECTIVES/SERVICE TASKS

OBJECTIVE 1: To provide members with professional care and treatment for infection and to relieve pain.

SERVICE TASKS

1.1 Provide emergency dental services within 24 hours of notification (service provided more than 24 hours after the incident is not considered emergent).

1.2 Review existing medical/dental data, assess the member's needs and develop a treatment plan and cost estimate before onset of treatment. PCP must be contacted at the time of the initial exam, if member is under age three (3).

1.3 The following services may be authorized as indicated in the treatment plan and approved by MIHS-HP:

a) emergency oral examination
b) radiographs (limited to symptomatic teeth)
c) composite resin involving incisal angle due to recent tooth fracture
d) prefabricated crowns (only to eliminate pain due to recent tooth fracture)
e) recementation of inlays and crowns
f) pulp cap - (direct or indirect) plus protective filling
g) vital pulpotomy
h) apicoectomy performed as a separate procedure on anterior teeth (for treatment of acute infection or to eliminate pain)
i) treatment for acute necrotizing ulcerative gingivitis
j) recementation of bridge
k) extractions
m) incision and drainage of abscess

n) treatment of fractures
o) appropriate anesthesia for optimal client management
p) non-complicated restorations (limited to the emergency tooth)
q) root canals - limited to six (6) anterior teeth (uppers and lowers) only, when indicated as treatment for acute infection or to eliminate pain

OBJECTIVE 2: To provide members with the construction or repair of dentures when determined medically necessary by the Medical Director or designee, including one follow-up visit within sixty (60) days of referral.

SERVICE TASKS

2.1 Provide comprehensive examination including, x-rays, molds or models, and construction of complete or partial dentures within sixty (60) days of referral.

2.2 Provide adjustments and one follow-up visit to members fitted with new, complete, or partial dentures at no extra charge, within thirty (30) days of delivery of dentures.

2.3 Provide permanent identification with member name on all new dentures as an additional expense to the price of fabrication and adjustment as indicated in Tasks 2.1 and 2.2.

2.4 Provide for relining or repair of dentures and one follow-up visit at no extra charge within thirty (30) days of provision of the prosthesis. These are billable expenses after that period.

OBJECTIVE 3: To provide members with laboratory, pre-operative, and post-operative procedures.

SERVICE TASKS

3.1 Prescribe necessary laboratory tests/radiographs.

3.2 Provide consultation to surgeon for any member requiring oral surgery.

3.3 Provide routine local anesthesia and pain management.

3.4 Recommend/Prescribe necessary drugs or medications.

3.5 Provide follow-up services.

OBJECTIVE 4: To provide high quality Early and Periodic Screening, Diagnosis and Treatment services (EPSDT) for eligible children from birth to twenty-one (21) years of age (See Attachment C).

SERVICE TASKS

4.1 Provide emergency dental services including:

a) Treatment of pain, infection, swelling and/or injury;
b) Extraction of symptomatic, infected and non-restorable primary and permanent teeth, as well as retained primary teeth; and

c) General anesthesia or conscious sedation when local anesthesia is contraindicated or when management of the member requires it.

4.2 Provide preventive dental services as specified in the EPSDT periodicity schedule, Exhibit 430-1, Chapter 400, AHCCCS Medical Policy Manual, including:

a) Instruction in self-care oral hygiene procedures;
b) Complete intraoral examinations;
c) Radiology procedures which are screening in nature for diagnosis of dental abnormalities, including panagraph or fullmouth x-rays; supplemental bitewing x-rays; and occlusal or periapical films as needed;
d) Oral prophylaxis performed by a dentist or dental hygienist;
e) Application of topical fluorides. (Use of a prophylaxis paste containing fluoride is not considered a separate fluoride treatment);
f) Dental sealants on all non-carious permanent first molars.

4.3 Provide all therapeutic dental services when they are considered medically necessary which may be subject to prior authorization by the MIHS-HP or program contractor. These services include but are not limited to:

a) Periodontal procedures, scaling/root planing, curettage, gingivectomy, osseous surgery.
b) Space maintainers when posterior primary teeth are lost prematurely.
c) Crowns:

1. Stainless steel crowns for both primary and permanent teeth;
2. Composite crowns for only anterior primary teeth;
3. Plastic or acrylic crowns for anterior primary teeth; or
4. Plastic or acrylic crowns for permanent teeth.

d) Pulp therapy for permanent and primary teeth, except third molars unless it is functioning in place of a missing molar.
e) Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations.
f) Provide dentures, orthodontics and orthognathic surgery when medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan designed by the PCP in consultation with the dentist.

4.4 For specialty referrals and dental appointments, Contractor shall provide services in accordance with AHCCCS requirements, as follows:

a) Emergency appointments within 24 hours of referral;
b) Urgent care appointments within three days of referral;
c) Routine care appointments within 30 days of referral.

4.5 The Contractor shall monitor and ensure that a member's waiting time after arrival in their office is no more than 45 minutes, except when the Contractor is unavailable due to an emergency.

4.6 PCP Contractors are, as a minimum requirement, to refer EPSDT members as a dental referral beginning at age three (3) years or sooner if problem occurs. Dental providers will follow the above reference appointment schedule requirements and office waiting times.

4.7 MIHS-HP will audit the accessibility of outpatient health care providers with the purpose of ensuring that MIHS-HP members have timely access to the provider's health care services as measured by the number of days it takes to obtain an appointment and in the number of minutes a member waits in the office to be cared for by the provider.

Objective 5: Contractor must comply with any and all licensing/certification requirements.

Service Tasks

5.1 Contractor shall not be operating under a provisional license or have been cited for a violation involving a Member's, Beneficiary's or Patient's life, health or safety in the last two years.

5.2 Contractor must be in compliance with OSHA Regulations regarding blood borne pathogens. Contractor must prove compliance by providing its exposure control plan for review. The plan must be acceptable to MIHS prior to a contract being awarded.

5.3 Contractor and Contractor's employees/subcontractors must not be under any sanctions, restriction or provisional status from the licensing/certifying agency.

5.4 Dentists, appropriate dental employees or subcontractors, who are practicing dentists must be licensed per A.R.S. Title 32, Chapter 11, Section 1231, et.seq.

5.5 The Contractor will fulfill all state licensing and regulatory requirements and applicable HCFA, ADHS, Title XIX, AHCCCS, JCAHO and other certifying/accrediting organization requirements in their care of the members. The Contractor is individually responsible for familiarization with all such licensing and regulatory requirements.

5.6 The Contractor shall have provided MIHS with a copy of the most current licenses and certifications for dentists and appropriate dental technician personnel during the Contract negotiation process and prior to the time of contract execution.

5.7 Follow dental standards established by the American Dental Association.

5.8 Contractor must be licensed to do business in the State of Arizona.

5.9 All applicable provisions of law and other rules and regulations of any and all governmental, accrediting and regulatory authorities relating to the licensure and regulation of physicians and hospitals shall be fully complied with by the Contractor.

SECTION III WORK STATEMENT
DENTAL SERVICES

Objective 6: Document and submit reports as requested by MIHS-HP staff.

Service Tasks

6.1 Contractor will submit copies of outpatient visits and any lab, imaging, or other test reports to the attention of the referring or ordering physician. If this information is not available, then the Authorization Unit should be contacted to obtain the name of the PCP.

6.2 Results of testing requiring follow-up by the referring physician should be communicated by fax or phone if urgent. Mail may be used for hospital records.

6.3 Records of visits and reports should include the following patient demographic information:

a) Member name, address, phone number
b) Member ID # (AHCCCS ID#, Social Security #, and/or Medicare #)
c) Date of birth
d) Primary Care Physician (PCP) or clinic (if known)

6.4 Contractor shall conduct and report to MIHS-HP the results of any self-monitoring activities involving MIHS-HP members.

6.5 The Contractor will submit the following reports to the Medical Management Department at the address listed below monthly by the 10th working day of each month:

a) Number, type, and dollar amount of services provided during the prior month, by member plan, age, and sex.
b) Number and type of services by Contractor site or member residence (zip code).
c) Number and type of services by diagnosis and procedures performed (Using ICD-9, CPT-4 and HCPCS codes as applicable).

Send the reports to:

Maricopa Integrated Health System – Health Plans
Medical Management Division
2516 East University –Building C
Phoenix, AZ 85034

SECTION III WORK STATEMENT
DENTAL SERVICES

4. LOCATION

Services provided under this Contract shall be provided at the Contractor's facilities listed below. Contractor must notify the Contract Management Department in writing, forty-five (45) days in advance of opening for any additional sites where service may be provided.

Site Name	Site Address	Phone	Fax	Hours

SECTION III WORK STATEMENT

ORAL/MAXILLOFACIAL SURGERY SERVICES

3.0 WORK STATEMENT – ORAL/MAXILLOFACIAL SURGERY

1. SERVICE GOAL

The goal of this service provides oral and maxillofacial surgery services for maintenance of dental health and the prevention and treatment of disease, injury or other dental conditions.

2. UNIT OF SERVICE

One (1) unit of service equals one (1) diagnostic procedure, and/or one (1) treatment procedure and/or one (1) laboratory, pre-operative, or post-operative procedure; and/ or one complete fabrication of dentures (either full or partial) to include x-rays, molds, models, and construction as well as any or all additional fittings.

3. SERVICE OBJECTIVES/SERVICE TASKS

OBJECTIVE 1: To provide members with professional diagnosis, surgical and adjunctive treatment of facial pain, facial infection, orofacial deformities, facial injuries, temporomandibular joint dysfunction (TMJ), care and treatment of disease.

SERVICE TASK

Review existing medical/dental data, assess the member's needs and develop a treatment plan and cost estimate before onset of treatment. . PCP must be contacted at the time of the initial exam, if member is under age three (3).

OBJECTIVE 2: To provide members with laboratory, pre-operative, and post-operative procedures.

SERVICE TASKS

2.1 Prescribe necessary laboratory tests/radiographs.

2.2 Provide consultation to referring physician for any member requiring oral surgery.

2.3 Provide routine local anesthesia and pain management.

2.4 Recommend/Prescribe necessary drugs or medications.

2.5 Provide follow-up services.

Objective 3: Contractor shall provide services in a timely manner.

Service Tasks

3.1 Contractor shall provide timely and appropriate professional Oral and Maxillofacial Surgery Services that meet or exceed community standards to MIHS-HP members.

3.2 The Contractor is responsible for providing coverage in the event of vacation, illness, or any other absence by Contractor.

3.3 For specialty referrals and dental appointments, Contractor shall provide services in accordance with AHCCCS requirements as follows:

a) Emergency appointments within 24 hours of referral;
b) Urgent care appointments within three days of referral;
c) Routine care appointments within 30 days of referral.

3.4 The Contractor shall monitor and ensure that a member's waiting time after arrival in their office is no more than 45 minutes, except when the Contractor is unavailable due to an emergency.

3.5 PCP Contractors are, as a minimum requirement, to refer EPSDT members as a dental referral beginning at age three (3) years or sooner if problem occurs. Dental providers will follow the above reference appointment schedule requirements and office waiting times.

3.6 MIHS-HP will audit the accessibility of outpatient health care providers with the purpose of ensuring that MIHS-HP members have timely access to the provider's health care services as measured by the number of days it takes to obtain an appointment and in the number of minutes a member waits in the office to be cared for by the provider.

Objective 4: Contractor must comply with any and all licensing/certification requirements.

Service Tasks

4.1 Contractor shall not be operating under a provisional license or have been cited for a violation involving a Member's, Beneficiary's or Patient's life, health or safety in the last two years.

4.2 Contractor must be in compliance with OSHA Regulations regarding blood borne pathogens. Contractor must prove compliance by providing its exposure control plan for review. The plan must be acceptable to MIHS prior to a contract being awarded.

4.3 Contractor and Contractor's employees/subcontractors must not be under any sanctions, restriction or provisional status from the licensing/certifying agency.

4.4 Dentists, appropriate dental employees or subcontractors, who are practicing dentists must be licensed per A.R.S. Title 32, Chapter 11, Section 1231, et.seq.

4.5 The Contractor will fulfill all state licensing and regulatory requirements and applicable HCFA, ADHS, Title XIX, AHCCCS, JCAHO and other certifying/accrediting organization requirements in their care of the members. The Contractor is individually responsible for familiarization with all such licensing and regulatory requirements.

4.6 The Contractor shall have provided MIHS with a copy of the most current licenses and certifications for dentists and appropriate dental technician personnel during the Contract negotiation process and prior to the time of contract execution.

4.7 Follow dental standards established by the American Dental Association.

4.8 Contractor must be licensed to do business in the State of Arizona.

4.9 All Applicable provisions of law and other rules and regulations of any and all governmental, accrediting and regulatory authorities relating to the licensure and regulation of physicians and hospitals shall be fully complied with by the Contractor.

Objective 5: Document and submit reports upon request by MIHS-HP staff.

Service Tasks

5.1 Submit copies of outpatient visits and any lab, imaging, or other test reports to the attention of the referring or ordering physician. If this information is not available, then the Authorization Unit should be contacted to obtain the name of the PCP.

5.2 For inpatients, copies of the discharge summary, operative reports, admission history and physical exam, and any pertinent test results or consultations should be sent to the referring or ordering physician and to MIHS-HP staff upon request.

5.3 Results of testing requiring follow-up by the referring or ordering physician should be communicated by fax or phone if urgent. Mail may be used for hospital records.

5.4 Records of visits and reports should include the following patient demographic information:

a) Member name, address, phone number
b) Member ID # (AHCCCS ID#, Social Security #, and/or Medicare #)
c) Date of birth
d) Primary Care Physician (PCP) or clinic (if known)

5.6 Contractor shall conduct and report to MIHS-HP the results of any self-monitoring activities involving MIHS-HP members.

5.7 The Contractor will submit the following reports to the Medical Management Department monthly at the address listed below by the 10th working day:

a) Number, type, and dollar amount of services provided during the prior month, by member plan, age, and sex.
b) Number and type of services by Contractor site or member residence (zip code).
c) Number and type of services by diagnosis and procedures performed (Using ICD-9, CPT-4 and HCPCS codes as applicable).

SECTION III WORK STATEMENT
ORAL/MAXILLOFACIAL SURGERY SERVICES

Send the reports to:

Maricopa Integrated Health System – Health Plans
Medical Management Division
2516 East University –Building C
Phoenix, AZ 85034

4. LOCATION

Services provided under this Contract shall be provided at the Contractor's facilities listed below. Contractor must notify the Contract Management Department in writing, forty-five (45) days in advance of opening for any additional sites where service may be provided.

Site Name	Site Address	Phone	Fax	Hours

4.0 INSTRUCTIONS TO RESPONDENTS

This Review of Qualifications (ROQ) package contains all the information and forms necessary to complete and submit a response. Respondents are encouraged to review the ROQ package in detail prior to commencing work.

4.1 General Directions

Any person, firm, corporation or association submitting a response shall be deemed to have read and understood all the terms, conditions and requirements in the specifications. Conditional responses will not be considered. All responses must be signed by an authorized signatory; unsigned responses may be rejected.

All responses and accompanying documentation will become the property of Maricopa County at the time responses are opened. Responses deemed to be non-responsive will be returned to the Respondent.

4.2 Required Response Format

To assist in the evaluation process, all responses must follow the same format. Responses in any other format may be considered informal and may be rejected.

One original and one (1) copy of the response must be submitted in the following order. The original must be labeled as such.

- Table of Contents
- Authorization to Submit Response and Required Certifications (Attachment E)
- Two (2) Letters of Reference (Do not include references from partners) (Attachment F)
- Professional Qualifications:
  - Arizona Dental License
  - ADA Board Certification
  - DEA License
  - Curriculum Vitae
  - List of Hospital Privileges, if applicable
- List of office locations, phone numbers, and business hours (Attachment G)
- Description of sanctions placed by any licensing or credentialing body, and most recent deficiency reports
- Signed Pricing Acceptance (Attachment H)
- Completed Provider Information Form (Attachment I)
- Signed Authorization/Release Form (Attachment J)
- Signed Addenda Cover Page(s) to this ROQ (if applicable)
- Respondent's Checklist (Attachment K)

4.3 Authorization to Submit Response

Attachment F must be completed and signed by a person authorized to make a binding offer for the dentist. The original signed document must be included in the submission.

4.4 Professional References

Respondents must use the format provided in Attachment H for Professional References. Acceptable letters are those from dentists, hospitals, or managed care organizations. Please do not submit letters of reference from business partners.

4.5 Professional Qualifications

Respondents are to supply the following items in the order listed: Arizona dental license; ADA board certification; DEA license; curriculum vitae; list of hospital privileges (if applicable); description of sanctions placed by any licensing or credentialing body and most recent deficiency report(s).

4.6 List Of Office Locations, Phone Numbers And Business Hours

The information provided by the Respondent on Attachment G will become part of Section III, Work Statement, paragraph 4. LOCATIONS. List only those locations for which services would be provided to MIHS members.

4.7 Price Acceptance

Attachment H is to be used by the Respondent to indicate acceptance of the MIHS rates for Dental and/or Oral Maxillofacial Services.

4.8 Provider Information Form

If awarded a contract, the information submitted on Attachment I will be used to ensure that the Provider Services Department has the most current information entered into the MIHS provider database.

4.9 Authorization/Release Form

Attachment J must be signed and submitted with the Respondent's submission. All information submitted in this application will be treated by MIHS and all agencies receiving this information as confidential and protected under Arizona State Statutes. The information from this application and other sources will be used by the MIHS Credentialing Department to evaluate and obtain each potential dental services provider.

4.10 Signed Addenda

It is the Respondent's obligation to assure that they have received and reviewed all Addenda issued. Respondents must include a signed Addenda cover page for each Addenda issued in relation to this ROQ within their submission. Respondents who fail to submit all signed Addenda may be deemed non-responsive and may be rejected. Addenda returned to MIHS separately from the Response will not be retained.

4.11 Respondent's Checklist

A Respondent's Checklist is included to assist in preparing the response for submission (Attachment K). It lists all items necessary to assemble a complete response. A completed Respondent's checklist must be included with the submission.

4.12 Submission of Response

Complete submissions must be delivered in sealed parcels with the Number 60-02-003-ROQ and the dentist's name clearly visible on the outside of the parcel. Completed and sealed Responses, including one original and 1 copy must be delivered to the location specified below. Sealed parcels must be physically in the possession of the MIHS Contracts Management, 2611 East Pierce, 2nd Floor, Phoenix, Arizona 85008 by 2:00 p.m., August 3, 2001 in order to be reviewed for the first round of evaluations . **RESPONSES SUBMITTED AFTER 2:00 P.M., AUGUST 3, 2001 WILL BE REVIEWED AS RECEIVED.**

4.13 Insurance Requirements

Upon award of a contract with Maricopa Integrated Health System, Respondent must show proof of Commercial General Liability, Professional Liability, and Workers' Compensation. Maricopa County must be named as additional insured. (See Section I, General Provisions, paragraph 22 for minimum coverage requirements).

4.14 Proprietary Information

Any information that is deemed proprietary by a Respondent must be clearly identified as such. The Respondent shall submit justification for any information designated as proprietary in nature. Final determinations of nondisclosure, however, rest with the Procurement Officer.

The County will not be held accountable if material from responses is obtained by parties other than the County without the written consent of the Respondent.

4.15 Respondent's Inquiries

All questions related to the content and requirements of this solicitation must be submitted in writing to Brian Maness.

Questions will be accepted by mail, fax or email at the following addresses:

Mail: Brian Maness
Maricopa Integrated Health System
Contracts Management
2611 E. Pierce Street, 2nd Floor
Phoenix, Arizona 85008

Fax: (602) 344-1813
Phone: (602) 344-1430

E-mail: Brian.Maness@hcs.maricopa.gov

Inquiries may be submitted by telephone, but must be followed up in writing. No oral communication is binding on MIHS.

4.16 Rights of MIHS

MIHS reserves the right to reject any or all responses or any part thereof, or to accept any response, or any part thereof, or to withhold the award or to waive or decline to waive irregularities in any response when it determines that it is in its best interest to do so.

5.0 CONTRACT CLAUSES

The following Sections and Attachments are a reflection of the final contract document.

Section I – General Provisions
Section II – Special Provisions
Section III – Work Statement **(see Section 3.0 of this ROQ)**
Section IV – Compensation
Attachment A – AHCCCS Subcontract Provisions
Attachment B – How to File a Claim
Attachment C – EPSDT Periodicity schedule
Attachment D – Health Plans Evidence of Coverage
    Maricopa Health Plan
    Maricopa Senior Select Plan
    Maricopa Long Term Care Plan
Attachment G – Locations, Phone numbers, business hours. This information becomes part of the final Work Statement(s)

SECTION I GENERAL PROVISIONS

1. ORDER OF PRECEDENCE

To the extent that the Special Provisions, if any, are in conflict with the General Provisions, the Special Provisions shall control. To the extent that the Work Statement is in conflict with the General Provisions or the Special Provisions, then the Work Statement shall control. To the extent that the Compensation Provisions are in conflict with the General Provisions, Special Provisions or Work Statement, then the Compensation Provisions shall control.

2. DEFINITIONS

As used in this Contract, the following terms shall have the meanings set forth below:

Arizona Health Care Cost Containment System (AHCCCS) means Arizona's Medicaid program and the state's health care program for persons who do not qualify for Medicaid.

Arizona Long Term Care System (ALTCS) means a component of AHCCCS, which, in addition to acute care and behavioral health services, provides long term care services and case management to eligible elderly and/or physically disabled (E/PD) members and developmentally disabled (DD) members, through contractual and other arrangements.

Beneficiary means any person designated by or on behalf of a Payer or funder as eligible to receive Covered Services under a Payer Contract.

Benefit Plan means the health care services for which a Beneficiary is eligible and the conditions and circumstances under which payment will be made for such services on behalf of the Beneficiary.

Billed Charges means charges billed by a provider for rendering services to a Member, Beneficiary or Patient.

CEO means the Chief Executive Officer of Maricopa Integrated Health System or his/her designee.

Clean Claim means a claim that may be processed to adjudication without obtaining additional information from the Contractor or provider of service or from a third party, but it does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

Comprehensive Health Center (CHC) means the Family Health Center, located on the Maricopa Medical Center campus, which provides outpatient primary and specialty care services.

Contract means this document and all its attachments and amendments, including where applicable, contractors/respondents proposal.

Contractor means the person, firm or organization listed on the cover page of this Contract and includes its agents, employees, and sub-contractors.

Copayment means a payment made to the participating health care provider by a Plan Member or Beneficiary at the time that selected services are rendered.

County means Maricopa County, a political subdivision of the State of Arizona.

Covered Services means those services and supplies payable under AHCCCS, Medicare, a Health or Benefit plan, an insurance, payer, grant agreements or a Payer Contract that are, if applicable, pre-authorized and provided to a Member as part of a specified Benefit Plan.

Department means any Department of Maricopa County other than Maricopa Integrated Health System.

Family Healthcare Centers (FHC) means one or more of the 13 facilities listed below:

Avondale FHC
950 East Van Buren
Avondale, AZ 85323
Phone: (623) 344-6800

Chandler FHC
811 South Hamilton
Chandler, AZ 85225
Phone: (480) 344-6100

Comprehensive Health Ctr.
2601 East Roosevelt
Phoenix, AZ 85008
Phone: (602) 344-1015

El Mirage FHC
12428 W. Thunderbird
El Mirage, AZ 85335
Phone: (623) 344-6500

Glendale FHC
5141 West LaMar
Glendale, AZ 85301
Phone: (623) 344-6700

Guadalupe FHC
5825 East Calle Guadalupe
Guadalupe, AZ 85283
Phone: (480) 344-6000

Maryvale FHC
4011 North 51st Ave.
Phoenix, AZ 85031
Phone: (623) 344-6900

McDowell FHC
1144 East McDowell Rd.
Phoenix, AZ 85006
Phone: (602) 344-6550

Mesa FHC
59 South Hibbert
Mesa, AZ 85202
Phone: (480) 344-6200

Scottsdale FHC
6535 E. Osborn Rd, Bldg 8
Scottsdale, AZ 85252
Phone: (480) 344-6050

Seventh Avenue FHC
407 South 9th Ave
Phoenix, AZ 85009
Phone: (602) 344-6600

South Central FHC
33 West Tamarisk Ave.
Phoenix, AZ 85040
Phone: (602) 344-6400

Sunnyslope FHC
934 West Hatcher Road
Phoenix, AZ 85020
Phone: (602) 344-6300

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable state or federal law.

Grievance means a complaint concerning an adverse action, decision, or policy by Contractor, its sub-contractor, non-contracted provider, MIHS, or the AHCCCS Administration, presented by an individual or entity.

Health Care Financing Administration (HCFA) means the federal agency, within the Department of Health and Human Services that administers Medicare and Medicaid.

JCAHO means the Joint Commission for the Accreditation of Healthcare Organizations.

Maricopa Health System means Maricopa Medical Center (MMC) and the Family Healthcare Centers (FHCs).

Maricopa Integrated Health System (MIHS) means the component of Maricopa County Government that operates the Maricopa Health System and the MIHS Health Plans.

Maricopa Medical Center (MMC) means the hospital component of MIHS located at 2601 East Roosevelt, Phoenix, Arizona.

MIHS Health Plans (MIHS – HP) means the component within MIHS that operates the managed care plans including Maricopa Health Plan (MHP), Maricopa Long Term Care Plan (MLTCP), HealthSelect (HS) and Maricopa Senior Select Plan (MSSP) as defined herein.

Member means a person enrolled in a MIHS Health Plan.

Non-Covered Services means all services that are other than Covered Services.

Participating Provider means a qualified provider of primary care services or other providers of health care services, including hospitals and providers of post acute and ancillary services, who has entered into an agreement with the MIHS Health Plans to provide Covered Services to Members or Beneficiaries.

Patient means any individual who is provided health care at a MIHS owned, operated or contracted health care facility or by a MIHS contracted provider.

Payer means any party other than MIHS and Contractor who is obligated to make payments to MIHS and/or the Contractor pursuant to a contract or standards of participation for the provision of health care services.

Payer Contract means an agreement between MIHS and a Payer or Funder, pursuant to which MIHS agrees to provide or arrange to provide Covered Services to Members, Patients, or Beneficiaries.

Plan means a health benefits plan under which a Payer/Funder has contracted with MIHS to provide or arrange, to provide Covered Services to enrolled Members, Beneficiaries or Patients.

Subcontractor means a subcontractor to the Contractor for performance under this Contract.

3. LAWS, RULES AND REGULATIONS

A. This Contract and Contractor is subject to all state and federal laws, rules and regulations that pertain hereto, including OSHA statutes and regulations.

B. If this Contract is written for the purpose of providing services to Arizona Health Care Cost Containment System (AHCCCS) or Arizona Long Term Care System (ALTCS) members, then the requirements contained herein are subject to the requirements of the AHCCCS/ ALTCS Approved Subcontract provisions (see Attachment A), since the Contractor under this Contract would become a Sub-Contractor of AHCCCS and subject to AHCCCS' regulations, policies and procedures, as applicable to this Contract.

If this Contract is written for the purpose of providing services to MSSP members, the requirements contained herein are subject to the requirements of the Health Care Financing Administration (HCFA) relating to Medicare and applicable programs, such as Medicare + Choice. Therefore, the Contractor is a subcontractor of HCFA, and must comply with applicable Medicare laws, rules and regulations and is subject to HCFA's rules and regulations, policies and procedures, as applicable to this Contract.

C. The terms of this Contract shall be construed in accordance with the laws, ordinances, rules, regulations and zoning restrictions of the United States of America, the State of Arizona, County of Maricopa, and the appropriate municipality; any action thereon shall be brought in the appropriate court in the State of Arizona.

4. NO GUARANTEED VOLUME

MIHS makes no representations nor guarantees the Contractor any maximum or minimum volume,

payment, reimbursement, member assignment or number of units of service to be provided.

5. NON-EXCLUSIVE STATUS

MIHS reserves the right to have the same or similar service provided by a provider other than the Contractor. Contractor will not be obligated to render professional services exclusively on behalf of MIHS or to Members or Patients; provided however, that such non-MIHS activities do not hinder, impair or conflict with Contractor's ability to fully perform its obligations under this Contract.

6. UNIVERSALITY

This Contract is awarded on behalf of Maricopa County in its entirety. Any Department in Maricopa County that has need, of the services identified herein may utilize such services. Such use by other County Departments will require an amendment to this Contract to adjust the issues related to such, other services, specify the process for claims submission, and address any other Department's processes that vary from this Contract.

7. COOPERATION WITH OTHER CONTRACTORS AND SUBCONTRACTORS

Contractor shall fully cooperate with other MIHS contractors and subcontractors and carefully plan and perform its own work to accommodate the work of other MIHS contractors. The Contractor shall not commit or permit any act, which will interfere with the performance of work by any other contractor, with the exception of those necessary to protect Members from danger.

8. SAFEGUARDING OF CONFIDENTIAL AND PRIVILEGED MEMBER INFORMATION

MIHS and Contractor shall safeguard confidential and privileged Member and Patient information i.e., medical, financial and patient specific information in accordance with all applicable federal, state and local laws, rules, and/or regulations. The use or disclosure by any party of any information concerning a Member or Patient served under this Contract or any other applicable Payer Contract is directly limited to services under this Contract subject to applicable federal, state and local laws, rules and/or regulations. Contractor's obligation to maintain the confidentiality of all medical, financial and patient specific information shall exist after termination or expiration of this Contract.

9. SUPPLY AND OWNERSHIP OF INFORMATION

Each party shall supply to the other party, upon request, any available information that is relevant to this Contract or any other applicable Payer Contract and to the performance of the parties hereunder.

Subject to applicable state and federal laws, rules and regulations, including without limitation those concerning confidentiality of Member and Patient records, MIHS shall have shared ownership rights to such records whether housed by Contractor or MIHS and the shared right to inspect, reproduce, duplicate, distribute, display, disclose and otherwise use all records, reports, information, data and material prepared by the Contractor in performance of the Contract.

10. LICENSES AND PERMITS

A. The Contractor shall, without limitation, obtain and maintain all licenses, permits, and authority necessary to do business, render services, and perform work under this Contract, and shall comply

with all laws regarding unemployment insurance, disability insurance, and worker's compensation. Contractor shall pay all charges and fees necessary and incidental to the lawful conduct of his business. He shall keep himself current and fully informed of existing and future federal, state, and local laws, ordinances and regulations, which in any manner affect the fulfillment of this contract and shall comply with the same.

B. The Contractor and Contractor's employees and subcontractors must not be under any sanctions, restrictions or provisional status from any applicable federal or state licensing/certifying/ credentialing agency, including but not limited to JCAHO.

11. TAX AND INSURANCE OBLIGATIONS

Contractor assumes sole and exclusive responsibility for payment of any state and federal income taxes, federal social security taxes, workmen's and unemployment insurance benefits for its physicians, staff, agents and employees as well as any and all other mandatory governmental deductions or obligations; in addition, Contractor assumes sole and exclusive responsibility for any pension or retirement program(s) for its physicians, staff, agents or employees whether required by law or not; in connection with the obligations contained in this paragraph, Contractor shall indemnify, defend and hold harmless Maricopa County or AHCCCS for any and all liability which Maricopa County and AHCCCS may incur as a result of Contractor's failure to pay such taxes or any such financial responsibility, as well as Maricopa County's and AHCCCS's liability for any such taxes or mandatory governmental obligations.

12. RETENTION AND ADEQUACY OF RECORDS

The Contractor agrees to retain all financial books, records, and other documents pertaining to this Contract or any other applicable Payer Contract for at least six years after final payment or until six years after the resolution of any audit questions or disputes. The County, MIHS, state or federal auditors and any other persons duly authorized by MIHS shall have full access to, and the right to examine, copy and make use of any and all said materials. The Contractor's medical and clinical record system will provide accurate, timely, complete, organized and legible information.

13. CONTRACT COMPLIANCE MONITORING

A. MIHS shall monitor the Contractor's compliance with and performance under this Contract. On-site visits for compliance monitoring may be made by MIHS, its designees and/or its Payer/Funder at any time during the Contractor's normal business hours, announced or unannounced. The Contractor shall make available for inspection and copying for MIHS' monitors, all records and accounts relating to the work performed or the services provided under this Contract or any other applicable Payer Contract. Upon request, the Contractor will investigate and respond in writing to appropriate MIHS staff concerns within ten (10) calendar days of receipt or notification of a request.

B. If MIHS needs the assistance or expertise of a private accounting, auditing, health care financing or contract compliance firm, and if Contractor and Maricopa County agree in writing, they will equally share such expenses.

C. Contractor agrees to take timely corrective action to resolve any problem identified from monitoring findings.

D. MIHS may change or add to such requirements, laws, rules and regulations from time to time.

14. AUDIT AND AUDIT DISALLOWANCE

SECTION I GENERAL PROVISIONS

A. MIHS reserves the right to audit any financial records of the Contractor or any Subcontractor(s), which relate to the terms under this Contract including services and billings made to MIHS. Such audits will be made at MIHS' expense at a time and place convenient to the Contractor. If the Contractor desires to participate in the selection of the auditor, the Contractor must be willing to share equally in the costs.

B. MIHS representatives displaying MIHS identification shall have the right during normal business hours, to enter the Contractor's facility for the purpose of examining records and related documents pertaining to services performed under this Contract or any other applicable Payer Contract and Contractor shall make available such records as requested.

C. If at any time it is determined by MIHS that a service or commodity for which payment has been made is disallowed, MIHS shall notify the Contractor in writing with the required course of action. It is at MIHS's option to submit an invoice to Contractor for the amount, to adjust any future claim submitted by the Contractor in the amount of the disallowance or to require repayment plus interest at the rate provided in ARS § 44-1202 of the disallowed amount by the Contractor.

D. Contractor, upon written notice, shall reimburse MIHS for any payments made under this Contract which are disallowed by a state, federal or Maricopa County audit in the amount of the disallowance.

E. Should either party undertake court action concerning a disallowance, the prevailing party shall receive, as part of its remedy, compensation for reasonable attorney fees, costs, expenses and court costs.

15. COUNTY RECOUPMENT RIGHTS

In addition to any other remedies set forth in this Contract, MIHS has the right to recoup, offset or withhold from Contractor any monies that Contractor has received but not yet provided the services, or where such monies should not have been provided to Contractor under the terms of this Contract or any other Payer Contract or where MIHS is obligated to recoup under state or federal laws.

16. DISPUTES

Except as otherwise provided by law, any dispute arising under this Contract shall be submitted to the Maricopa County Dispute Process as specified in Maricopa County Procurement Code Article 9 (available at www.maricopa.gov) as amended from time to time.

17. NON-DISCRIMINATION

The Contractor shall not in any way discriminate against any Member or Patient on the grounds of race, color, religion, sex, national origin, age, disability, health status and genetics, political affiliation or belief. The Contractor shall include a clause to this effect in all its pertinent subcontracts. The Contractor shall also comply with all applicable provisions of the Americans with Disabilities Act of 1990.

18. EQUAL EMPLOYMENT OPPORTUNITY

The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex national origin, age or disability. The Contractor will take affirmative action to insure that applicants are employed and that employees are treated during employment without regard to their race, color, religion, sex, national origin, age or disability. Such action shall include, but not be limited

to, the following: employment, upgrading, demotion or transfer, recruitment or recruitment advertising, lay-off or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship. The Contractor will, to the extent such provisions apply, comply with Title VI and VII of the Federal Civil Rights Act; the Federal Rehabilitation Act; the Age Discrimination in Employment Act; the Americans with Disabilities Act of 1990; the Immigration Reform and Control Act (IRCA) of 1986; and Arizona Executive Order 99-4 which mandates that all persons shall have equal access to employment opportunities.

19. COVENANT AGAINST CONTINGENT FEES

The Contractor warrants that no person or selling agency has been employed or retained to solicit or secure this Contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee excepting bona-fide employees or bona-fide established commercial or selling agencies retained by the Contractor for the purpose of securing business. For breach or violation of this warranty, MIHS shall have the right to terminate this Contract without liability and at its sole discretion, to deduct from the Contract price or consideration, or otherwise recover, the full amount of such commission, percentage, brokerage, or contingent fee.

20. INDEPENDENT CONTRACTOR STATUS AND NON-LIABILITY

A. The Contractor is an Independent Contractor in the performance of all work and the provision of all services under this Contract and is not to be considered an officer, employee, or agent of Maricopa County.

B. This Contract is not intended to constitute, create, give rise to or otherwise recognize a joint venture agreement or relationship, partnership or formal business organization of any kind, and the rights and obligations of the parties shall be only those expressly set forth in the contract.

C. Maricopa County and its officers and employees shall not be liable for any act or omission by the Contractor occurring in the performance under this Contract or any other applicable Payer Contract, nor shall the County be liable for purchases or contracts made by the Contractor in anticipation of funding hereunder.

21. INDEMNIFICATION

A. To the fullest extent permitted by law, the Contractor shall indemnify, defend and hold harmless the County and MIHS, its agents, representatives, officers, directors, officials and employees from and against any and all claims, damages, losses and expenses (including but not limited to attorney fees, court costs) relating to, arising out of, or alleged to have resulted from the Contractor's acts, errors, omissions or mistakes relating to any professional services as well as any other activity of or by Contractor under this Contract or any other Payer Contracts that are incorporated into this Contract. Contractor's duty to hold harmless, defend and indemnify the County, its agents, representatives, officers, directors, officials and employees shall arise in connection with any claim, damage, loss or expense that is attributable to bodily injury, sickness, disease, death, or injury to, impairment, or destruction of property including loss of use resulting therefrom, caused by any acts, errors, mistakes or omissions related to any professional services as well as any other activity under the terms of this Contract, or any other Payer Contracts that are incorporated into this Contract, including any person for whose acts, errors, mistakes or omissions the Contractor may be legally liable.

In addition to the indemnification obligations set forth above, if the Contractor provides goods or

services other than direct patient care services under this Contract, Contractor must provide for the defense and defend County and MIHS in any actions referenced above.

B. Nothing in this Contract or any other Payer Contracts that are incorporated into this Contract may be construed as limiting the scope of the indemnification provisions contained in this Contact.

C. The provisions of this paragraph and the Contractor's indemnification obligation will survive beyond the expiration or termination of this Contract.

22. INSURANCE PROVISIONS AND REQUIRED COVERAGE, TERM AND TERMINATIONS

A. **General.** The Contractor shall, at its own expense, purchase and maintain the minimum insurance specified below with companies duly licensed, with a current A.M. Best, Inc. Rating of B++6, or approved unlicensed by the State of Arizona Department of Insurance.

B. **Additional Insured.** The insurance coverage, except Workers' Compensation, required by this Contract, shall name the County, its agents, representatives, officers, directors, officials and employees as Additional Insured.

C. **Duration of Coverage.** All insurance required herein shall be maintained in full force and effect during the term of this Contract and until all work or services required to be performed has been satisfactorily completed and formally accepted by MIHS. Thereafter, the insurance and indemnification provisions contained in this Contact will extend beyond the termination date of this Contract.

D. **Tail Coverage.** In the event any insurance policy (ies) required by this Contract are written on a "claims made" basis, coverage shall extend for at least two years beyond the termination of this Contract, and such coverage shall be evidenced in the Certificates of Insurance.

E. **Claim Reporting**. Any failure to comply with the claim reporting provisions of Contractor's policies or any breach of a policy warranty shall not affect Contractor's obligations or coverage afforded under the policies to protect the County.

F. **Waiver (Subrogation)**. The policies, except Workers' Compensation, shall contain a waiver of transfer rights of recovery (subrogation) against the County, its agents, representatives, directors, officers, and employees for any claims arising out of the Contractor's work or service.

G. **Deductible/Retention.** Contractor's policies may provide coverage, which contain deductibles or self-insured retention's. The Contractor shall be solely responsible for the deductible and/or self-insured retention.

H. **Certificates of Insurance.** Prior to commencing work or services under this Contract, Contractor shall furnish the County with Certificates of Insurance, or formal endorsements evidencing that the required policies and/or coverage are in full force and effect during term of this Contract and where relevant, thereafter. All Certificates of Insurance shall be identified with this Contract number and title.

I. **Cancellation and Expiration Notice.** Insurance required by the terms of this Contract shall not expire, be canceled, or materially changed without 15 days prior written notice to the County. If a policy does expire during the life of this Contract, a renewal Certificate must be sent to the County fifteen (15) days prior to the expiration date.

J. **Copies of Policies.** The County reserves the right to request and receive, within 10 working days of the request, certified copies of any or all of the above policies and/or endorsements referenced herein.

K. **Primary Coverage.** Contractor's insurance shall be the primary insurance under the terms of this contract as respects the County; any insurance or self insurance program maintained by County shall not contribute to Contractor's insurance obligations hereunder.

L. **Types of Coverage Required.** Contractor is required to procure and maintain the following coverages indicated by a checkmark:

☒ **1. Commercial General Liability.** Commercial General Liability insurance with a limit of not less than 1,000,000 for each occurrence and with a $1,000,000 General Aggregate Limit. The policy shall include coverage for bodily injury, broad form property damage, personal injury, products and completed operations and blanket contractual covering; the liability assumed under the indemnification provisions of this Contract shall be at least as broad as Insurance Service Office, Inc. Policy Form CG 00011093 or any replacements thereof. The Commercial General Liability additional insured endorsement will be at least as broad as the Insurance Service Office, Inc, Additional Insured, Form B, and CG 20101185.

Such policy shall contain a severability of interest provision, and shall not contain a sunset provision or commutation clause, or any provision, which would serve to limit any third party action over claims.

☐ **2. Automobile Liability.** Commercial/Business Automobile Liability insurance with a combined single limit for bodily injury and property damage of not less than $500,000 each occurrence with respect to any of the Contractor's owned, hired, and non-owned vehicles assigned to or used in performance of the Contractor's work or services under this Contract. Coverage will be at least as broad as coverage code 1, "any auto", (Insurance Service Office, Inc. Policy Form CA 00011293, or any replacements thereof).

☒ **3. Workers' Compensation.** Workers' Compensation insurance to cover obligations imposed by federal and state statutes having jurisdiction of Contractor's employees engaged in the performance of the work or services under this Contract; and Employer's Liability insurance of not less than $100,000 for each accident, $100,000 disease for each employee, and $500,000 disease policy limit.

☒ **4. Professional Liability.** Professional Liability insurance (for health care, and health care related services) which will provide coverage for any and all acts arising out of the work or services performed by the Contractor under the terms of this Contract, with a limit of not less than $1,000,000 for each claim, and $3,000,000 for all (aggregate) claims.

☐ **5. Errors and Omissions Insurance.** Errors and Omissions Insurance, other than Professional Liability Coverage referenced above, which will insure and provide coverage for errors or omissions of the Contractor, with limits of no less than $1,000,000 for each claim and $3,000,000 in the aggregate.

23. ASSIST WITH DEFENSE IN LITIGATION

Contractor agrees to cooperate in the defense of lawsuits or other quasi-legal actions arising from work

performed under this Contract or any other applicable Payer Contract. Cooperation may include, but not be limited to, participating in depositions, interpreting medical records, meeting with County Attorney staff, or other representatives of the County.

24. USE OF COUNTY PROPERTY

A. The Contractor shall not use County premises, property (including equipment, instruments and supplies), or personnel for any purpose other than the performance of the duties under this Contract.

B. Contractor will be responsible for any damages to County property when such property is the responsibility of or in the custody of the Contractor, his employees or subcontractors.

25. SEVERABILITY

Any provision of this Contract which is determined to be invalid, void or illegal shall in no way affect, impair or invalidate any other provision hereof, and remaining provisions shall remain in full force and effect.

26. NO WAIVER OF STRICT COMPLIANCE

Acceptance by MIHS of performance not in strict compliance with the terms hereof shall not be deemed to waive the requirement of strict compliance for all future performance obligations.

27. PROHIBITION AGAINST LOBBYING

A. Pursuant to P.L.101-121 (31 U.S.C.§1352) recipients of federal contracts, grants, loans, or cooperative agreements are prohibited from using appropriated funds to pay anyone to influence or attempt to influence Congress, or an executive agency, in connection with any federal grant, contract or loan.

B. Contractor shall not use, directly or indirectly, any of the monies received pursuant to the terms of this Contract for purposes of lobbying, influencing, or attempting to influence, any governmental entity, public official or member of any state, county, or local governmental entity, with regard to any grant, contract or loan.

28. QUALITY MANAGEMENT

Contractor shall fully cooperate with MIHS to fulfill any quality management program requirements undertaken by MIHS or required by the Health Care Financing Administration (HCFA), AHCCCS/ALTCS, Arizona Department of Health Services (ADHS), and all other regulatory or accrediting bodies, including but not limited to the JCAHO, that pertain to services provided under this Contract.

29. YEAR 2000 COMPLIANCE

SECTION I GENERAL PROVISIONS

Any and all products and/or services supplied by the Contractor shall be Year 2000 compliant, meaning that the information technology accurately processes date and time data from, into, and between the 20th and 21st centuries.

30. CERTIFICATION OF COST AND PRICING DATA

A. The Contractor certifies that, to the best of its knowledge and belief, any cost or pricing data submitted is accurate, complete and current as of the date submitted or mutually agreed upon date. The price(s) may be adjusted to exclude any amounts by which MIHS finds that the price was increased because the Contractor furnished cost or pricing date that was inaccurate, incomplete or not current as of the date of certification. The Contractor has a continuing duty to report to MIHS that the price was increased because the cost or pricing data was inaccurate, incomplete or not current as off the date of certification. The certifying of cost or pricing data does not apply when federal or state law or regulations set contract rates.

B. Where applicable, the Subcontractor's rate shall not exceed that of the Contractor's rate, as bid in the pricing sections, unless the Contractor is willing to absorb any higher rates. The Subcontractor's invoice shall be invoiced directly to the Contractor, who in turn shall pass-through the costs to MIHS, without mark-up. A copy of the Subcontractor's invoice must accompany the Contractor's invoice.

31. USE OF CONTRACTOR'S NAME, SYMBOLS AND SERVICE MARKS

MIHS may utilize Contractor's name as one of its Contractors or providers in its marketing literature. Use of the Contractor's name for any other purpose requires Contractor's prior approval.

While each party agrees to permit the other to use that party's address, photograph, telephone number, and description of services in its regulatory documentation or for marketing purposes, neither party may use the other party's name, symbols or trademarks, nor any proprietary information without prior written approval of the other party.

32. CONTRACTORS COMPLIANCE WITH PAYER POLICIES AND PROCEDURES

MIHS and Contractor will comply with policies and procedures imposed by Payers regarding services performed by Contractor or MIHS under a Payer Contract, including but not limited to prior authorization, encountering, claim submission and verification of Covered Services provision.

33. NO THIRD PARTY BENEFICIARY RIGHTS

The obligation of each party under this Contract is intended to solely benefit the other party. No other person shall be a third party beneficiary of this Contract, nor have any rights under this Contract.

34. TERM OF THIS CONTRACT AND RIGHT TO EXTEND

The term of this Contract shall be as set forth on the Cover Page, unless otherwise terminated or extended in accordance with the terms of this Agreement.

Subject to the availability of funds and acceptable Contractor performance, MIHS may extend this Contract for additional periods, not to exceed a total term of five years from the Effective Date.

35. ADJUSTMENTS TO CONTRACT TERM AND PRICE

Requests for change in Contract terms, including price adjustments, shall be submitted by Contractor 120 days prior to the expiration date. Any increase in the cost of service or price, must be mutually acceptable to MIHS and the Contractor and be incorporated into this Contract by amendment.

36. ASSIGNMENTS

A. Neither this Contract, nor any portion thereof, may be assigned to another party by Contractor without the written consent of the CEO. Any attempt by the Contractor to assign any portion of this Contract without the written consent of MIHS shall constitute a breach of this Contract, and may render this Contract null and void.

B. No assignment shall alter the Contractor's legal responsibility to MIHS to assure that all of the provisions under this Contract are carried out. All terms and conditions in this Contract shall be included in all Contractor's assignments.

C. Maricopa County may, upon 90 days prior written notice, and without the consent of the other party hereto, assign this Contract.

37. SUBCONTRACTS

A. No subcontract alters the Contractor's legal responsibility to MIHS to assure that all of the provisions under this Contract are carried out. All terms and conditions in this Contract shall be included in all Contractor's subcontracts.

B. Contractor may enter into Subcontractor agreements with qualified providers or with professional corporations. All such subcontracts are subject to the review and prior approval of MIHS.

C. Contractor agrees that it is liable and responsible for any act or omission by the Subcontractor, its employees, agents, officers and representatives, occurring in the course of Contractor's performance of this Contract, whether such act or omission occurs on County property or elsewhere. Contractor shall be liable for any loss or damage arising out of or related to Subcontractor's performance of this contract. Contractor shall bear the above stated liability for all consequential, incidental, direct, and indirect damages, and shall be liable for all costs, including attorney's fees, incurred by MIHS to enforce this provision, even in absence of its own negligence, unless County actions caused the loss or damage.

D. If Contractor is a professional corporation, professional limited liability company, partnership or other association, Contractor shall obligate in writing each of its shareholders, members, partners or professional employees who may perform services under this Contract, to comply with all of the terms and conditions of this Contract.

E. The CEO may require the termination of any subcontract or subcontractor for the reasons set forth in Paragraph #39, Termination.

38. AMENDMENTS

A. All Amendments to this Contract must be in writing and signed by both parties.

B. When MIHS issues an amendment, the Contractor shall sign and return the required number of original copies of the amendment. The provisions of such amendment will be deemed to have been accepted 60 days after the date of mailing by MIHS even if the amendment has not been signed by

the Contractor, unless within that time the Contractor notifies MIHS in writing that it refuses to sign the amendment. If the Contractor provides such notification, MIHS will initiate a Dispute or Termination proceeding, as appropriate.

C. MIHS may, by written amendment, make changes within the general scope of this Contract. If any such amendment causes an increase or decrease in the cost of, or the time required for, performance of any part of the work under this Contract, the Contractor or MIHS may assert its right to an equitable adjustment in compensation paid under this contract. The Contractor or MIHS must assert its right to such adjustment within 30 days from the date of receipt of the change notice.

39. TERMINATION

A. Termination For Convenience

Either party may terminate this Contract at any time with 90 days notice in writing to the other party. This provision does not preclude MIHS from terminating the Contract sooner under other applicable provisions of this Contract.

B. Termination By Mutual Agreement

This Contract may be terminated by mutual written agreement of the parties specifying the termination date therein.

C. Termination For Cause

MIHS may terminate this Contract for cause upon 14 calendar days written notice to the Contractor. Such cause may include, but not be limited to, the following:

(1) Breach of this Contract which is not corrected within 14 calendar days after written notice thereof, served by certified or registered mail, return receipt requested.

(2) Professional misconduct as determined by MMC's Medical Staff in accordance with the MMC's Medical Staff Bylaws or Rules and Regulations.

(3) Continual neglect of duty or violation of MMC's or MMC's Medical Staff Bylaws, Rules and Regulations, or policies.

(4) Inability to discharge the duties and responsibility under this Contract for a continual period of 14 calendar days or more.

D. Immediate Termination

(1) MIHS may terminate this Contract immediately when the life, health or safety of a Member, Beneficiary, Patient, County employee or County Contracted employee is jeopardized by the activities or inactivities of Contractor.

(2) MIHS may also terminate this Contract immediately, with notice to the Contractor, upon the occurrence of any of the following events:

a. Loss, restriction or suspension of Contractor's license, certification or other authority

essential to its ability to perform its obligations under this Contract including, but not limited to, decertification from participation in the AHCCCS, Medicaid or Medicare programs,

b. Insolvency, dissolution or bankruptcy of the Contractor.

E. Termination - Availability Of Funds

If any action is taken by any state agency, federal department, county government or any other agency, payer or instrumentality to suspend, decrease, or terminate its fiscal obligations under, or in connection with, this Contract or any other applicable Payer Contract, MIHS may amend, suspend, decrease, or terminate its obligations under, or in connection with, this Contract. In the event of termination, MIHS shall be liable for payment only for services rendered prior to the effective date of the termination, provided that such services performed are in accordance with the provisions of this Contract or any other applicable Payer Contract. MIHS shall give written notice at least 10 days in advance of the effective date of any suspension, amendment, or termination under this section.

Such notice shall be given by personal delivery or by Registered or Certified mail. The Contractor shall be entitled to receive just and equitable compensation for work in progress, work completed and materials accepted before the effective date of the termination.

F. Obligations Of Provider Upon Termination

Contractor shall use best efforts to transfer care of Members to other Providers as soon as practical upon suspension or termination of this Contract by MIHS. Contractor is responsible for care of Members until they are accepted by another qualified provider and is obligated to accept payment rates stated herein for those services rendered from MIHS or any other Payer.

G. If this Contract is terminated on the bases of Paragraph(s) 39. A, B, or D, the provisions of Paragraph 16, Disputes, do not apply.

40. DEFAULT

The County may suspend, modify or terminate this Contract in whole or in part, immediately upon written notice to Contractor in the event of a non-performance of stated objectives or any other material breach of contractual obligations; or upon the happening of any event which would jeopardize the ability of the Contractor to perform any of its contractual obligations. Maricopa County reserves the right to have service provided by other than the Contractor if the Contractor is unable or fails to provide requested service within the specified time frame or in the contractually prescribed manner.

41. AVAILABILITY OF FUNDS

The provisions under this Contract or any other applicable Payer Contract relating to payment for services shall become effective when funds assigned for the purpose of compensating the Contractor as herein provided are actually available to MIHS for disbursement. The CEO shall be the sole judge and authority in determining the availability of funds and MIHS shall keep the Contractor fully informed as to the availability of funds.

42. CONTRACTOR'S CONDUCT

Contractor will not engage in any conduct, activities, business or professional arrangements that jeopardize this Contract or Contractor's performance, obligations or duties under this Contract.

43. RIGHT OF CANCELLATION PER A.R.S. § 38-511

Notice is given that pursuant to A.R.S. § 38-511 the County may cancel this contract without penalty or further obligation within three years after execution of the contract, if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of the County is at any time while the contract or any extension of the contract is in effect, an employee or agent of any other party to the contract in any capacity or consultant to any other party of the contract with respect to the subject matter of the contract.

Additionally, pursuant to A.R.S. § 38-511 the County may recoup any fee or commission paid or due to any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of the County from any other party to the contract arising as the result of the contract

SECTION II SPECIAL PROVISIONS

1. ORDER OF PRECEDENCE

To the extent that the Special Provisions, if any, are in conflict with the General Provisions, the Special provisions shall control. To the extent that the Work Statement is in conflict with the General Provisions or the Special Provisions, then the Work Statement shall control. To the extent that the Compensation Provisions are in conflict with the General Provisions, Special Provisions or Work Statement, then the Compensation Provisions shall control.

2. DEFINITIONS

As used in this Contract, the following terms shall have the meanings set forth below:

Advance Directive means a written statement completed in advance of serious illness. The statement indicates what kind of medical treatment a Patient, Beneficiary or Member does or does not want under special serious medical conditions should they become mentally or physically unable to communicate their wishes. Common forms of advance directives are: Living Will, Durable Health Care Power of Attorney and Mental Health Care Power of Attorney.

Ancillary Care means x-rays, laboratory, ambulance, transportation, pharmacy services, therapies, dialysis, and other medically related services.

Appeal means a request for a standard or expedited reconsideration of the denial of a requested service or payment of a service.

Authorization/Prior Authorization means an administrative process whereby MIHS Health Plans reviews and approves requested services after determining medical necessity and appropriateness.

Authorization Number means the reference or tracking number issued by the MIHS Health Plans Authorization Unit for a specific service or group of services.

Authorization Unit means the MIHS Health Plans Medical Management component responsible for service authorization, consultation and tracking.

Case Manager means the person or persons designated by MIHS to develop and monitor the overall plan for a Member's care with specific diagnosis or who require extensive services. The roles of case managers are service coordinator, advocate, facilitator, counselor and gatekeeper. The case management services provided are: intake and screening; assessment of needs and informal and formal supports; care plan development to insure appropriate care with the best outcome; service authorization; coordination and monitoring; advocacy; reassessment of needs on a regular basis; and termination or closure.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, with an average knowledge of health and medicine, could reasonable expect the absence of immediate medical attention to result in:

1) serious jeopardy to the health of the individual (or an unborn child);
2) serious impairment to bodily functions; or
3) serious dysfunction of any bodily organ or part.

Emergency Medical Services means services provided after the sudden onset of a medical condition

manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1) placing the patients health in serious jeopardy;
2) serious impairment of bodily functions; or
3) serious dysfunction of any bodily organ or part.

Emergency Services (for Medicare and MSSP Members only) means covered inpatient or outpatient services that are:

1) furnished by a qualified provider and
2) needed to evaluate or stabilize an emergency medical condition.

EPSDT (Early and Periodic Screening, Diagnosis and Treatment) means the service program for AHCCCS acute care and ALTCS eligible persons and Members under 21 years of age. EPSDT includes general screening, diagnostic and treatment services including vision, dental and hearing services.

Evidence of Coverage (EOC) means the document that explains Covered Services and defines a Plan's obligation and the Member's rights and responsibilities.

Explanation of Benefits (EOB) means a record of a claim sent to the Member after the claim is filed and processed, which shows the services billed, whether the services are covered, and how deductibles, co-insurance or benefit maximums were applied and includes the general appeals process.

Maricopa Health Plan (MHP) means the managed care plan of MIHS Health Plans designed to serve Arizona Health Care Cost Containment System (AHCCCS) acute care enrollees.

Maricopa Long Term Care Plan (MLTCP) means the managed care plan of MIHS Health Plans designed to serve ALTCS elderly and physically disabled Members.

Maricopa Senior Select Plan (MSSP) means the Medicare + Choice managed care plan of MIHS Health Plans, serving Medicare Beneficiaries residing in Maricopa County.

Medicare + Choice (M+C) means a managed care option offered to eligible Medicare Beneficiaries.

MIHS-HP Medical Director means the physician or designee designated by MIHS to monitor and review the provision of covered services to Members of MIHS' Health Plans.

Member Month means one month of covered services for one enrolled Member.

Primary Care Physician (PCP) means the individual physician who practices the specialty of general practice, internal medicine, adolescent and pediatric medicine, family practice, or obstetrics/gynecology, and those working at his or her direction and who is under contract with MIHS. The PCP also provides, arranges for, and coordinates the provision of Medically Necessary Covered Services to Beneficiaries, Members, or Patients, including initiating and monitoring referrals to Specialists or Specialist Groups when appropriate pursuant to this Contract.

Qualified Medical Provider means a physician duly qualified and licensed to practice medicine in Arizona and who is board certified or board eligible or a physician or non-physician paraprofessional or

health care provider, who is certified or licensed to practice his or her health care specialty in Arizona, and who meets the qualifications established by MIHS, and where applicable, credentialed by MMC and/or MIHS Health Plans, and who provides services to MIHS Members or Patients.

Quality Control Peer Review Organization (PRO) means an organization contracted by MIHS or by HCFA to promote quality care services for Medicare Beneficiaries, to determine if services rendered are medically necessary, appropriate, and meet professional recognized standards of care.

Specialty Care Provider means a Qualified Medical Provider who practices a specific medical or surgical specialty and who contracts for various health care services which may include, but are not limited to, accepting referrals from Primary Care Physicians for the purpose of providing Covered Services in their specialty to MIHS Members, Beneficiaries or Patients.

Urgent Care Services means medical services required promptly to prevent impairment of health due to symptoms that a prudent lay person would believe require immediate attention but are not life-threatening and do not pose a high risk of permanent damage to an individual's health. Urgent Care Services are appropriately provided in a clinic, physician's office or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care Services do not include Emergency Services and Non-Symptomatic Services.

Urgent Care Services (for Medicare and MSSP Members only) means covered services provided when a Member is temporarily absent from the M+C plan's service area that are immediately required as a result of:

1) an unforeseen illness, injury or condition; and
2) it is not reasonable, given the circumstances, to obtain the services through the organization offering the M+C plan.

3. STANDARDS

A. Dental coverage for MIHS-HP members is restricted to the specific coverage requirements of the specific member's health plan. (Attachment D, Benefits Schedule).

B. Contractor must receive referrals from Authorization Unit only.

C. All non-emergency dental services must be authorized by the Medical Director or designee consistent with the individual member's enrollment plan and a treatment plan must be approved by the Primary Care Physician for other than MSSP members.

D. Maintain comprehensive dental charting to include tooth charting, periodontal screening when possible, complete x-ray diagnosis, oral hygiene assessment and family/guardian or emergency contact person's name and telephone number.

E. Signed consent for irreversible procedures must be obtained from member, guardian, or personal representative.

F. Monitor office appointment availability and wait times. The Office Waiting Time Standard is 45 minutes. Office waiting time is measured from the time of the scheduled appointment until the member is seen by the dentist or other professional. If the scheduled appointment is for 10:00 a.m. and the member is by the dentist at 10:30 a.m., the measured waiting time is 30 minutes. If the

member chooses to arrive before 10:00 a.m., that time is not counted in total waiting time. Office appointments and waiting time data are submitted to MIHS-HP twice a year as instructed by MIHS-HP Medical Management Division.

4. ACCOUNTABILITY

When the purpose of this Contract is to provide services to MSSP members, MIHS - HP shall oversee and is accountable to HCFA for any functions and responsibilities described in the M+C regulations. Should MIHS – HP choose to delegate any of these functions, it shall do so in compliance with the requirements of the M+C regulations.

5. REFERRALS AND PROHIBITIONS AGAINST SOLICITATION

The Contractor will not advise, counsel, solicit or refer any Member to facilities, health plans or providers, other than Maricopa Medical Center or other County designated health care providers, except in accordance with written MIHS policies or procedures for services not available from or provided by Maricopa Medical Center or other County designated health care providers. Nothing in this Contract shall preclude the Contractor from making medically necessary or appropriate referrals of Members or other Patients to persons or entities that are not parties to this Contract, provided any such referrals comply with applicable MIHS written policies and procedures.

6. CREDENTIALING

A. MIHS will thoroughly investigate the qualifications of each dentist and/or Subcontractor(s) prior to their provision of service to Department members.

B. Credentials of such providers shall be verified from the primary sources, wherever feasible and as appropriate for the provider's level of licensure/certification. MIHS shall secure information as described in the most current NCQA, AHCCCS, Federal, State and Department standards.

C. MIHS may delegate the credentialing activities.

D. The Contractor shall provide Department with relevant information concerning new dentists and/or subcontractors, any resignations/terminations or any restriction or supervision requirements exceeding thirty (30) days.

E. The Contractor agrees to cooperate fully with MIHS during the credentialing process by responding within five (5) working days to requests for information regarding dentists and/or subcontractors.

SECTION II SPECIAL PROVISIONS

F. The Contractor consents and agrees to cooperate with MIHS or its delegate/agent during periodic practice site visits, medical record reviews or both.

G. The final decision regarding the granting of initial privileges or renewal/ reappointment rests solely with MIHS. At the time of initial credentialing the decision of MIHS is final and not subject to appeal. However, this action would not prevent an applicant from reapplying at some later date.

H. If, at the time of renewal/reappointment, or otherwise during the course of the contract, MIHS denies or restricts the privileges of a dentist and/or subcontractor, he/she shall be entitled to all procedural rights as described in the Hearing and Appellate review policies and procedures of MIHS.

I. At least every two (2) years MIHS shall conduct a renewal/ reappointment of each dentist and/or subcontractor. MIHS shall secure information as described in the most current NCQA, AHCCCS, Federal, State and Department standards.

J. Contractor shall fully cooperate with MIHS to fulfill any credentialing requirements of MIHS, state or federal regulatory agencies, MIHS Payers if so required or other accreditation, licensing or credentialing authority, including, but not limited to, JCAHO, which pertain to any services provided under this Contract.

K. Contractor must successfully complete the MIHS credentialing process prior to treating any MIHS-HP Patients, and Contractor's continued participation under this Contract is contingent upon successful completion of the MIHS recredentialing process (recredentialing occurs at a minimum once every two years of more frequently if requested by MIHS).

L. During the interim period between reappointment cycles, Contractor shall provide MIHS with current copies of Arizona and Drug Enforcement Agency (DEA) licenses and proof of insurance.

M. Contractor shall provide MIHS with documentation that it is currently in good standing with all applicable state and federal regulatory agencies or other accreditation and licensing authorities, including, but not limited to, JCAHO or NCQA, prior to the provision of service under this Contract. Thereafter, Contractor is to remain in good standing with all of the aforementioned agencies and authorities.

N. Contractor shall notify MIHS or its credentialing service in writing within two working days after the Contractor receives notice by any organization of any change in the Contractor's professional status, including, but not limited to, suspension, termination, probation, resignation, or any other change in its licensure, qualifications or hospital privileges. This notice must be provided to MIHS or its credentialing service by fax and followed by certified mail.

O. Contractor will immediately notify if it receives any restriction or any limitations to its licensure, accreditation or certification status, as well as any restriction or limitation on its practice or operations. Contractor shall also provide copies of any statement of deficiencies, corrective actions, plans and timelines for implementation, including those requested by MIHS.

P. Contractor will maintain and provide MIHS with documentation regarding his/her hospital privileges.

Q. Contractor shall immediately notify MIHS of any change in office location, telephone numbers, hours of business, or addition or deletion of any dentist.

R. Contractors, who are not subject to any state or federal regulatory or accrediting body, shall fully comply with all MIHS policies, procedures, and standards.

7. THIRD PARTY LIABILITY

Except for Maricopa Senior Select Plan Members, Contractor agrees to accept Medicare or any other third-party liability coverage. Contractor agrees to first seek such Medicare or third-party liability payment before submitting claims to MIHS for reimbursement and to engage in Coordination of Benefits activity with such other third-party Payers.

8. IMMUNIZATION REQUIREMENTS

Contractors who provide direct patient care to MIHS Health Plan Members at non-MIHS facilities: Contractor shall ensure that its employees, agents and subcontractors meet minimum health standards. Upon request, the Contractor shall provide MIHS with a current health status report (within the past 12 months) for each of its employees, agents and subcontractors who have worked in a MIHS facility. The health status report shall include, without limitation:

1) Proof of immunity or immunization for varicella, rubella and rubeola.
2) Proof of current diptheria/tetanus immunization.
3) Documentation of TB screen (within the past 12 months).
4) Documentation of Hepatitis B antibody screen or signed declination statement.
5) Date of last complete physical exam.

9. QUALITY MANAGEMENT COMPLIANCE

In addition to the language in Section I, General Provisions, Paragraph 40 QUALITY MANAGEMENT A - D of this paragraph apply to agencies with a governing body, and C and D apply to individual providers. For agencies with a governing body, the Contractor shall submit a statement signed by it's governing body attesting to A-D. Individual Contractor's shall or will submit a signed statement attesting to C and D of the following:

A. The Contractor's governing body shall require, support and oversee a quality assessment and improvement program designed to monitor and evaluate the quality, utilization and appropriateness of member care, resolve identified problems and improve member care.

B. There is a written plan for the quality assessment and improvement program that describes the program's objectives, organization, scope and mechanisms for overseeing the effectiveness of monitoring, evaluation and problem-solving activities including the effectiveness of care, i.e., under-utilization of prevention and disease management services in accordance with MIHS-HP practice guidelines. The written plan is reviewed and signed by the governing body on an annual basis.

Upon request, the Contractor shall submit a copy of the current signed quality assessment and improvement plan including Quality and Utilization Management functions.

C. The Contractor agrees to work collaboratively with MIHS-HP in the development, collecting, implementation, measurement and reporting of outcome indicators. There is a written plan for biannual (twice a year) quality of care and utilization of services self-monitoring activities that describes the Contractor's mechanisms for overseeing the effectiveness of care. The written plan includes identification of quality of care and over and under-utilization of services for prevention and disease management services as defined by MIHS-HP's practice guidelines, policies and procedures.

EXAMPLE: Quality and Utilization Management Meeting Minutes related to MIHS-HP Aggregate data on patient encounters, services rendered, diagnoses, procedures performed.

Clinical Outcome indicators as directed by regulatory bodies and/or indicated by MIHS-HP standards.

D. When a problem or an opportunity to improve care or services is identified by either MIHS-HP, regulatory or accrediting bodies or the Contractor, the Contractor shall submit a written plan of improvement to MIHS-HP. The time frame for the submission of the plan shall be established by MIHS-HP who will review, accept or request modification of the plan. MIHS-HP may choose to accept plans of improvement required by regulatory or accrediting bodies or request that an additional plan be submitted. The Contractor shall include in the written plan and carry out the following:

1) action to improve care/services or correct the problem;
2) monitoring of the effectiveness of the action and take further action if the problem is not improved or resolved; and
3) submit to MIHS-HP documented evidence of actions and results.

10. EXPERIMENTAL TREATMENT

A. Experimental treatment will be evaluated on a case by case basis for authorization.

B. For the purposes of this contract, a drug, a treatment, a device, a procedure shall be considered experimental and investigational if:

1) It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use.

2) It is the subject of a current investigational new drug or new device application on file with the FDA.

3) It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial.

4) It is being provided pursuant to a written protocol that describes among its objectives, determinations of safety, efficacy, or efficacy in comparison to conventional alternatives, toxicity.

5) It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS).

6) The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings.

7) If the predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness or effectiveness compared with conventional alternatives.

8) It is not investigational in itself pursuant to the above, and would not be medically necessary, but for the provision of a drug, device, treatment, or procedure which is investigational or experimental.

C. Objective criteria will be reviewed to determine if the experimental treatment will be approved/disapproved. The exclusive sources of information for obtaining the objective criteria shall be the following:

1) The member's medical records.

2) The protocol(s) pursuant to which the treatment is to be delivered.

3) Any consent document the member has executed or will be asked to execute, in order to undergo the procedure.

4) The published authoritative medical or scientific literature regarding the procedure at issue as applied to the injury or illness at issue (published in this context is extremely meaningful and should be emphasized).

5) Regulations and other official actions and publications issued by the FDA and HHS.

SECTION III WORK STATEMENT

SEE SECTION 3.0 OF THIS ROQ

SECTION IV COMPENSATION
DENTAL AND/OR ORAL MAXILLOFACIAL SURGERY SERVICES

1. COMPENSATION

A. Subject to the availability of funds, MIHS will, within 30 days from the date of receipt of the clean claim, process and remit to the Contractor, a warrant for payment up to the maximum total allowable for the previous month of service provision or work performance. Should MIHS make disallowance in the claim, the claim shall be processed for the reduced amount. Contractor shall be notified in writing of the amount and reasons for any disallowances and shall be afforded the opportunity to document the appropriateness of the disallowed costs and to resubmit a claim for payment. Contractor will direct all claims inquiries to the Claims Research Unit at (602) 344-8555. If the Contractor does not understand or disputes the findings of the Claims Research Unit they should call Provider Services at (602) 344-8957 for assistance. If the Contractor does not believe that there has been a fair resolution of the issue, they may initiate the Disputes process in accordance with the Disputes clause of this contract.

B. The Contractor understands and agrees that MIHS will not honor any claim submitted beyond the allowable time frame. Initial claims for payment must be submitted within six months after date of service. Clean claims must be resubmitted as a clean claim no more than 12 months after the date of service. MSSP claims will follow Medicare guidelines. Contractor understands and agrees that MIHS will not process any claim for payment for services rendered prior to the Contract expiration date which are submitted 60 days after the Contract expiration date without approval of the Vice President, Health Plans.

C. Contractor will first bill Medicare, except for Maricopa Senior Select Plan (MSSP) members and any other applicable third party payor for eligible members. The Contractor agrees that no amount in excess of the co-payment will be billed to MIHS for Medicare covered services to non-MSSP members. However, MIHS will accept and reimburse claims on behalf of non-MSSP Medicare members when the only basis for a denial is that the annual deductible has not been met. Such claims must be itemized separately and billed as specified in Paragraph 3, METHOD OF PAYMENT.

D. Billing MIHS-HP members

1) MIHS-HP AHCCCS and ALTCS members and/or their family shall not be billed for any service or portion thereof performed under this Contract. MIHS-HP Maricopa Senior Select Plan (MSSP) members shall only be billed for designated co-pays in connection with this Contract.

2) MSSP members shall only be billed for the following co-payments:

c. Dental $5.00 + 20% of covered dental benefits

4) However, the above restrictions do not preclude Contractor from entering into a separate agreement with these individuals to provide services that are not covered and/or authorized by MIHS-HP. Contractor should have a written agreement, signed by the individual, prior to the provision of service. The agreement should clearly state that the member understands that MIHS-HP will not pay for the service and that they agree to pay for it.

SECTION IV COMPENSATION

DENTAL AND/OR ORAL MAXILLOFACIAL SURGERY SERVICES

2. PRICING

Dental Services

A. During the term of this Contract, the maximum amount of compensation due Contractor from Maricopa County for any and all services performed and the obligations and duties hereunder shall not exceed a percentage of the dental pool of $7,300,000.

B. Subject to the availability of funds, MIHS will pay the Contractor for authorized services at the rate of 100% of the AHCCCS Fee For Service Schedule (April 1, 2001 edition) or the Contractor's billed charges, whichever is less, as full payment for services delivered (A.R.S.36-2903.01I or 36-2903-J) for an initial two (2) year term.

Oral/Maxillofacial Surgery Services

A. During the term of this Contract, the maximum amount of compensation due Contractor from Maricopa County for any and all services performed and the obligations and duties hereunder shall not exceed $50,000.

B. Subject to the availability of funds, MIHS will pay the Contractor for authorized services at the rate of 100% of the AHCCCS Fee For Service Schedule (April 1, 2001 edition) or the Contractor's billed charges, whichever is less, as full payment for services delivered (A.R.S.36-2903.01I or 36-2903-J) for an initial two (2) year term.

3. METHOD OF PAYMENT

A. Contractor will submit separate claims using the American Dental Association (ADA) Dental Claim Form to:

Maricopa Integrated Health System – Health Plans
P.O. Box 20019
Phoenix, Arizona 85036-0019

B. Claims must consist of the following information:

- provider's name
- AHCCCS provider number
- Health plan assigned provider ID suffix
- Federal Tax ID number
- MIHS-HP Authorization Number
- member's name
- member's identification number
- date(s) of service
- Diagnostic/Procedure/Revenue code(s)/NDC(s) as per instruction in Attachment B
- total charge
- itemized listing of services
- any additional data that AHCCCS/ALTCS may require
- Medicare and other third party liability Explanation Of Medical Benefits (EOMB)

ATTACHMENTS to ROQ

Attachment A	-	AHCCCS Minimum Provisions
Attachment B	-	How to File a Claim
Attachment C	-	EPSDT Periodicity Schedule
Attachment D	-	Benefits Schedule
Attachment E	-	Authorization to Submit Response and Required Certifications
Attachment F	-	Letters of Reference (2)
Attachment G	-	List of office locations, phone numbers and business hours
Attachment H	-	Price Acceptance
Attachment I	-	Provider Information Form
Attachment J	-	Authorization/Release Form
Attachment K	-	Respondent's Checklist
Attachment L	-	Quick Reference Guide (information only)

ATTACHMENT A: MINIMUM SUBCONTRACT PROVISIONS

[The following provisions must be included verbatim in every subcontract.]

1) EVALUATION OF QUALITY, APPROPRIATENESS, OR TIMELINESS OF SERVICES

The Arizona Health Care Cost Containment System Administration (AHCCCSA) or the U.S. Department of Health and Human Services may evaluate, through inspection or other means, the quality, appropriateness or timeliness of services performed under this subcontract.

2) RECORDS AND REPORTS

The Contractor shall maintain all forms, records, reports and working papers used in the preparation of reports, files, correspondence, financial statements, records relating to quality of care, medical records, prescription files, statistical information and other records specified by AHCCCSA for purposes of audit and program management. The Contractor shall comply with all specifications for record-keeping established by AHCCCSA. All books and records shall be maintained to the extent and in such detail as shall properly reflect each service provided and all net costs, direct and indirect, of labor, materials, equipment, supplies and services, and other costs and expenses of whatever nature for which payment is made to the Contractor. Such material shall be subject to inspection and copying by the state, AHCCCSA and the U.S. Department of Health and Human Services during normal business hours at the place of business of the person or organization maintaining the records.

The Contractor agrees to make available at the office of the Contractor, at all times reasonable times, any of its records for inspection, audit or reproduction, by any authorized representative of the state or federal governments.

The Contractor shall preserve and make available all records for a period of five years from the date of final payment under this subcontract except as provided in paragraphs a. and b. below:

a. If this subcontract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any such termination.

b. Records which relate to disputes, litigation or the settlement of claims arising out of the performance of this subcontract, or costs and expenses of this subcontract to which exception has been taken by the state, shall be retained by the Contractor until such disputes, litigation, claims or exceptions have been disposed of.

The Contractor shall provide all reports requested by AHCCCSA, and all information from records relating to the performance of the Contractor that AHCCCSA may reasonably require. The Contractor reporting requirements may include, but are not limited to, timely and detailed utilization statistics, information and reports.

3) LIMITATIONS ON BILLING AND COLLECTION PRACTICES

The Contractor shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCSA that the person was ineligible for AHCCCS on the date of service, or that services provided were not AHCCCS covered services. This provision shall not apply to patient contributions to the cost of services delivered by nursing homes.

ATTACHMENT A: MINIMUM SUBCONTRACT PROVISIONS

4) ASSIGNMENT AND DELEGATION OF RIGHTS AND RESPONSIBILITIES

No payment due the Contractor under this subcontract may be assigned without the prior approval of AHCCCSA. No assignment or delegation of the duties of this subcontract shall be valid unless prior written approval is received from AHCCCSA.

5) APPROVAL OF SUBCONTRACTS, AMENDMENTS OR TERMINATIONS

This subcontract is subject to prior approval by AHCCCSA. The prime contractor shall notify AHCCCSA in the event of any proposed amendment or termination during the term hereof. Any such amendment or termination is subject to the prior approval of AHCCCSA. Approval of the subcontract may be rescinded by the Director of AHCCCSA for violation of federal or state laws or rules.

6) WARRANTY OF SERVICES

The Contractor, by execution of this subcontract, warrants that it has the ability, authority, skill, expertise and capacity to perform the services specified in this contract.

7) SUBJECTION OF SUBCONTRACT

The terms of this subcontract shall be subject to the applicable material terms and conditions of the contract existing between the Contractor and AHCCCSA for the provision of covered services.

8) AWARDS OF OTHER SUBCONTRACTS

AHCCCSA and/or the prime contractor may undertake or award other contracts for additional or related work to the work performed by the Contractor and the Contractor shall fully cooperate with such other contractors, subcontractors or state employees. The Contractor shall not commit or permit any act which will interfere with the performance of work by any other contractor, subcontractor or state employee.

9) INDEMNIFICATION BY CONTRACTOR

The Contractor agrees to hold harmless the state, all state officers and employees, AHCCCSA and other appropriate state agencies, and all officers and employees of AHCCCSA and all AHCCCS eligible persons in the event of nonpayment to the Contractor. The Contractor shall further indemnify and hold harmless the state, AHCCCSA, other appropriate state agencies, AHCCCS contractors, and their agents, officers and employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the State, AHCCCSA or its agents, officers or employees, or AHCCCS contractors, through the intentional conduct, negligence or omission of the Contractor, its agent, officers or employees.

10) MAINTENANCE OF REQUIREMENTS TO DO BUSINESS AND PROVIDE SERVICES

The Contractor shall be registered with AHCCCSA and shall obtain and maintain all licenses, permits and authority necessary to do business and render service under this subcontract and, where applicable, shall comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation.

11) COMPLIANCE WITH LAWS AND OTHER REQUIREMENTS

The Contractor shall comply with all federal, State and local laws, rules, regulations, standards and executive orders governing performance of duties under this subcontract, without limitation to those designated within this subcontract.

12) SEVERABILITY

If any provision of these standard subcontract terms and conditions is held invalid or unenforceable, the remaining provisions shall continue valid and enforceable to the full extent permitted by law.

ATTACHMENT A: MINIMUM SUBCONTRACT PROVISIONS

13) VOIDABILITY OF SUBCONTRACT

This subcontract is voidable and subject to immediate termination by AHCCCSA upon the Contractor becoming insolvent or filing proceedings in bankruptcy or reorganization under the United States Code, or upon assignment or delegation of the subcontract without AHCCCSA's prior written approval.

14) CONFIDENTIALITY REQUIREMENT

Confidential information shall be safeguarded pursuant to 42 CFR Part 431, Subpart F, A.R.S. §36-107, 36-2903, 41-1959 and 46-135, and AHCCCS and/or ALTCS Rules.

15) GRIEVANCE AND REQUEST FOR HEARING PROCEDURES

Any grievance and request for hearings filed by the Contractor shall be adjudicated in accordance with AHCCCS Rules.

16) TERMINATION OF SUBCONTRACT

AHCCCSA may, by written notice to the Contractor, terminate this subcontract if it is found, after notice and hearing by the State, that gratuities in the form of entertainment, gifts, or otherwise were offered or given by the Contractor, or any agent or representative of the Contractor, to any officer or employee of the State with a view towards securing a contract or securing favorable treatment with respect to the awarding, amending or the making of any determinations with respect to the performance of the Contractor; provided, that the existence of the facts upon which the state makes such findings shall be in issue and may be reviewed in any competent court. If the subcontract is terminated under this section, unless the prime contractor is a governmental agency, instrumentality or subdivision thereof, AHCCCSA shall be entitled to a penalty, in addition to any other damages to which it may be entitled by law, and to exemplary damages in the amount of three times the cost incurred by the Contractor in providing any such gratuities to any such officer or employee.

17) PRIOR AUTHORIZATION and UTILIZATION REVIEW

The prime contractor and Contractor shall develop, maintain and use a system for Prior Authorization and Utilization Review which is consistent with AHCCCS Rules and the prime contractor's policies.

18) NON-DISCRIMINATION REQUIREMENTS

If applicable, the Contractor shall comply with:

a. The Equal Pay Act of 1963, as amended, which prohibits sex discrimination in the payment of wages to men and women performing substantially equal work under similar working conditions in the same establishment.

b. Title VI of the Civil Rights Act of 1964, as amended, which prohibits the denial of benefits of, or participation in, contract services on the basis of race, color, or national origin.

c. Title VII of the Civil Rights Act of 1964, as amended which prohibits private employers, state and local governments, and educational institutions from discriminating against their employees and job applicants on the basis of race, religion, color, sex, or national origin.

d. Title I of the Americans with Disabilities Act of 1990, as amended, which prohibits private employers and state and local governments from discriminating against job applicants and employees on the basis of disability.

e. The Civil Rights Act of 1991, which reverses in whole or in part, several recent Supreme Court decisions interpreting Title VII.

f. The Age Discrimination in Employment Act (A.R.S. Title 41-1461, et seq.); which prohibits discrimination based on age.

g. State Executive Order 99-4 and Federal Order 11246 which mandates that all persons, regardless of race, color, religion, sex, age, national origin or political affiliation, shall have equal access to employment opportunities.

h. Section 503 of the Rehabilitation Act of 1973, as amended, which prohibits discrimination in the employment or advancement of the employment of qualified persons because of physical or mental handicap.

i. Section 504 of the Rehabilitation Act of 1973, as amended, which prohibits discrimination on the basis of handicap in delivering contract services.

19) COMPLIANCE WITH AHCCCS RULES RELATING TO AUDIT AND INSPECTION

The Contractor shall comply with all applicable AHCCCS Rules and Audit Guide relating to the audit of the Contractor's records and the inspection of the Contractor's facilities. If the Contractor is an inpatient facility, the Contractor shall file uniform reports and Title XVIII and Title XIX cost reports with AHCCCSA.

20) CERTIFICATION OF TRUTHFULNESS OF REPRESENTATION

By signing this subcontract, the Contractor certifies that all representations set forth herein are true to the best of its knowledge.

21) CERTIFICATION OF COMPLIANCE - ANTI-KICKBACK and LABORATORY TESTING

By signing this subcontract, the Contractor certifies that it has not engaged in any violation of the Medicare Anti-Kickback statute (42 USC §§1320a-7b) or the “Stark I” and “Stark II” laws governing related-entity referrals (PL 101-239 and PL 101-432) and compensation therefrom. If the Contractor provides laboratory testing, it certifies that it has complied with 42 CFR §411.361 and has sent to AHCCCSA simultaneous copies of the information required by that rule to be sent to the Health Care Financing Administration.

22) CONFLICT IN INTERPRETATION OF PROVISIONS

In the event of any conflict in interpretation between provisions of this subcontract and the AHCCCS Minimum Subcontract Provisions, the latter shall take precedence.

23) ENCOUNTER DATA REQUIREMENT

If the Contractor does not bill the prime contractor (e.g., Contractor is capitated), the Contractor shall submit encounter data to the prime contractor in a form acceptable to AHCCCSA.

24) CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA) OF 1988

The Clinical Laboratory Improvement Amendment (CLIA) of 1988 requires laboratories and other facilities that test human specimens to obtain either a CLIA Waiver or CLIA Certificate in order to obtain reimbursement from the Medicare and Medicaid (AHCCCS) programs. In addition, they must meet all the requirements of 42 CFR 493, Subpart A.

To comply with these requirements, AHCCCSA requires all clinical laboratories to provide verification of CLIA Licensure or Certificate of Waiver during the provider registration process. Failure to do so shall result in either a termination of an active provider ID number or denial of initial registration. These

requirements apply to all clinical laboratories.

Pass-through billing or other similar activities with the intent of avoiding the above requirements are prohibited. Prime contractor may not reimburse providers who do not comply with the above requirements.

25) INSURANCE

[This provision applies only if the Contractor provides services directly to AHCCCS members]

The Contractor shall maintain for the duration of this subcontract a policy or policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Contractor agrees that any insurance protection required by this subcontract, or otherwise obtained by the Contractor, shall not limit the responsibility of Contractor to indemnify, keep and save harmless and defend the State and AHCCCSA, their agents, officers and employees as provided herein. Furthermore, the Contractor shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage, for itself and its employees, and AHCCCSA shall have no responsibility or liability for any such taxes or insurance coverage.

26) FRAUD AND ABUSE

If the Contractor discovers, or is made aware, that an incident of potential fraud or abuse has occurred, the Contractor shall report the incident to the prime contractor, who shall proceed in accordance with the *AHCCCS Health Plans and Program Contractors Policy for Prevention, Detection and Reporting of Fraud and Abuse*. Incidents involving potential member eligibility fraud should be reported to AHCCCSA, Office of Managed Care, Member Fraud Unit. All other incidents of potential fraud should be reported to AHCCCSA, Office of the Director, Office of Program Integrity. (See AHCCCS Rule R9-22-511.

ATTACHMENT B – FILING A CLAIM

Please refer to the following Maricopa Integrated Health System – Health Plans (MIHS-HP) policy when filing a claim, submitting a request for information or if you have a concern regarding a claim.

1. Authorization:

a. Before treating a MIHS-HP member you must obtain an authorization number or a Service Authorization Form (SAF). If you are requested to consult or render service to a member by another physician, you must obtain an authorization number.

b. For services authorized by an authorization number, call the Authorization Unit at 602-344-8111 or 1-800-552-8808 to obtain authorization to treat. You must give the member's name and date of birth to the Authorization Unit Nurse. If the member has a card, give the Authorization Unit Nurse the member's AHCCCS ID#. This office is staffed by RN's with physician back-up, 24 hours a day, seven days a week.

c. For services authorized via a Service Authorization Form (SAF), contact the Case Manager.

2. Filing a Claim:

a. The American Dental Association (ADA) Dental Claim Form must be used.

b. The authorization number, obtained from the Authorization Unit office, or from the Consultation Request form must be entered on the American Dental Association (ADA) Dental Claim Form.

c. A "clean claim" is defined by AHCCCS as "one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity."

Applicable supporting documentation must also accompany the claim, e.g.:

ER Report	Itemized Invoice
Treatment Record	Correct CPT-4 Codes
Admission Record	Operative Report
History and Physical	Medicare EOMB
Other Insurance EOB	Discharge Summary
CT/MRI Scan Report	Anesthesia Report/Units
Transportation Log	

d. Claims must be initially received within six (6) months of date(s) of service, pursuant to A.R.S 36-2904(H).

e. Claims lacking documentation and/or that are improperly completed will be denied based upon the clean claim provisions mandated by A.R.S 36-2904(H). These claims shall be returned to the provider for proper completion and additional documentation. Resubmitted clean claims must be received no later than twelve months from the date of service, must be identified as a "Resubmission", and must be accompanied by all relevant documentation, including copy of the denial remit.

ATTACHMENT B – FILING A CLAIM

f. *If member has Medicare, Medicare is the first payor. Medicgap, Supplemental other TPL coverage is the second payor. MIHS-HP is the payor of the last resort. MIHS-HP will pay its share after an EOMB has been provided along with the claim.

NOTE: THIS PARAGRAPH DOES NOT APPLY TO THE MSSP CONTRACT.*

3. Claims will be denied for the following reasons.

Member was not an MIHS-HP member on the date of service.

Authorization was not obtained from MIHS-HP or authorization was denied.

Claim exceeds time frames.

Claim did not achieve clean claim status within 12 months from date of service.

Other inappropriate or inaccurate information.

4. A provider who requires a claims status report may receive assistance by calling the Claims Research Unit at 602-344-8555.

ATTACHMENT B – FILING A CLAIM

INSTRUCTIONS FOR THE COMPLETION OF ADA DENTAL CLAIM FORM

ADA Claim Form Block Numbers	Description
1	Dentist's pre-treatment estimate; Dentist's statement of actual services; Provider ID#
2	Medicaid Claim; EPSDT; Prior Authorization #; Patient ID #
3	Carrier Name and Address
4	Patient's Name
5	Relationship to Employee
6	Sex
7	Patient's Birthdate
8	If full time student?
9	Employee/Subscriber Name and Mailing Address
10	Employee/Subscriber Dental Plan ID Number
11	Employee/Subscriber Birthdate
12	Employer (Company) Name and Address
13	Group Number
14	Is Patient Covered by Another Dental Plan?
15a	Name and Address of Carrier
15b	Group No.
16	Name and Address of Other Employers
17a	Employee/Subscriber Name (if different that patient)
17b	Employee/Subscriber Dental Plan ID Number
17c	Employee/Subscriber Birthdate
18	Relationship to Patient
19	Patient Signature and Date
20	Employee/Subscriber Signature
21	Name of Billing Dentist or Dental Entity
22	Address Where Payment Should be Remitted
23	City, State, Zip
24	Dentist Soc. Sec. Or TIN
25	Dentist License No.
26	Dentist Phone Number
27	First Visit Date
28	Place of Treatment
29	Radiographs or Models Enclosed
30	Is Treatment Result of Illness or Injury?
31	Is Treatment Result of Auto Accident?
32	Other Accident?
33	If Prosthesis, Is this Initial Placement?
34	Date of Prior Placement
35	Is Treatment for Orthodontics?
36	Identify Missing Teeth
37	Examination and Treatment Plan
38	Remarks for Unusual Services
39	Dentist Signature
40	Address Where Treatment Was Performed
41	Total Fee Charged
42	Payment by Other Plan

ATTACHMENT C
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
DENTAL PERIODICITY SCHEDULE

	Months	Years																		
Procedure	Birth through 36 months		3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+ up to 21
Dental Referral	+	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

Referrals for routine dental visits should begin at age three (3). Earlier initial dental evaluations may be appropriate for some children.

Key: + = birth to 36 months if indicated

x = to be completed

ATTACHMENT D – HEALTH PLANS BENEFITS SCHEDULE

Maricopa Health Plan Summary Dental Benefits:

- **All dental health checkups and treatments are covered for health plan members through age 20**
- **Once each year, members through the age of 20 are able to receive a $10 gift certificate for completion of their annual dental visit and exam**
- **Children do not need to be referred by their doctor (PCP) to a dentist**
- **Emergency dental care is the only dental care offered to members 21 and older**

Maricopa Long Term Care Plan Summary Dental Benefits:

- **All dental health checkups and treatments are covered for health plan members through age 20**
- **Once each year, members through the age of 20 are able to receive a $10 gift certificate for completion of their annual dental visit and exam**
- **Children do not need to be referred by their doctor (PCP) to a dentist**
- **Medically necessary dentures, transplantation services, and emergency dental care is the only dental care offered to members 21 and older**

ATTACHMENT E: AUTHORIZATION TO SUBMIT RESPONSE AND REQUIRED CERTIFICATIONS

The Respondent hereby certifies that they have read, understand, and agree to fully comply with all terms and conditions as set forth in the Maricopa County Procurement Code, and amendments thereto, together with the specifications and other documentary forms herewith made a part of this specific procurement.

The person signing the Response certifies that he/she is the person in the Respondent's organization responsible for, or authorized to make decisions for the dentist/surgeon.

The Respondent is a corporation or other legal entity.

No attempt has been made or will be made by the Respondent to induce any other firm or person to submit or not to submit a Response in connection to this ROQ.

- ❑ All Addenda to this ROQ issued by Maricopa County have been received by the person/organization below. All Addenda are signed and returned with the Response.
- ❑ No Addenda have been received.

The price and terms and conditions in this Response are valid for 120 days from the date of submission.

_____
NAME OF DENTIST OR SURGEON

_____
SPECIALTY

_____ (_____)
ADDRESS TELEPHONE

_____ (_____)
CITY STATE ZIP CODE FAX #

_____
E-MAIL ADDRESS

_____ N/A _____
AHCCCS ID NUMBER MEDICARE NUMBER FEDERAL TAX ID NUMBER

_____ _____
AUTHORIZED SIGNATURE DATE

_____
PRINTED NAME AND TITLE

==========

MINORITY BUSINESS/WOMEN BUSINESS/SMALL BUSINESS (check appropriate item):

___ Minority Business Enterprise (MBE)
___ Women Business Enterprise (WBE)
___ Small Business Enterprise (SBE)

ATTACHMENT F: PROFESSIONAL REFERENCES

Enter the information requested below for at least two professional references. Please do not submit references from partners.

REFERENCE #

Organization Name:_____

Address:_____

City/State/Zip:_____

Contact Person:_____ Title:_____

Contact Person Phone Number:_____

Description for Reference:

REFERENCE #

Organization Name:_____

Address:_____

City/State/Zip:_____

Contact Person:_____ Title:_____

Contact Person Phone Number:_____

Description for Reference:

ATTACHMENT G – LIST OF LOCATIONS, PHONE NUMBERS AND BUSINESS HOURS

Location #1:
Address:
City, State, Zip:
Phone:
Fax:
Hours:

Location #2:
Address:
City, State, Zip:
Phone:
Fax:
Hours:

Location #3:
Address:
City, State, Zip:
Phone:
Fax:
Hours:

Location #4:
Address:
City, State, Zip:
Phone:
Fax:
Hours:

Location #5:
Address:
City, State, Zip:
Phone:
Fax:
Hours:

ATTACHMENT H: PRICE ACCEPTANCE

The document is to be used by the Respondent to acknowledge acceptance of rates for Dental and/or Oral Maxillofacial Surgery Services.

Upon successful negotiations with Respondent(s), pricing information will be inserted into Section IV, Compensation, paragraph 2, Pricing.

The price and terms and conditions in this Response are valid for 120 days from the date of submission.

DENTAL SERVICES
During the term of this Contract, the maximum amount of compensation due Contractor from Maricopa County for any and all services performed and the obligations and duties hereunder shall not exceed a percentage of $7,300,000.

Subject to the availability of funds, MIHS will pay the Contractor for authorized services at the rate of 100% of the AHCCCS Fee For Service Schedule (June 1, 2000 edition) or the Contractor's billed charges, whichever is less, as full payment for services delivered (A.R.S.36-2903.01I or 36-2903-J) for an initial two (2) year term.

ORAL/MAXILLOFACIAL SURGERY SERVICES

During the term of this Contract, the maximum amount of compensation due Contractor from Maricopa County for any and all services performed and the obligations and duties hereunder shall not exceed a percentage of $50,000.

Subject to the availability of funds, MIHS will pay the Contractor for authorized services at the rate of 100% of the AHCCCS Fee For Service Schedule (April 1, 2001 edition) or the Contractor's billed charges, whichever is less, as full payment for services delivered (A.R.S.36-2903.01I or 36-2903-J) for an initial two (2) year term.

I hereby certify that _____ acknowledges acceptance of the rates for an
(Name of submitting dentist)
initial two (2) year term.

_____ _____ _____
Signature of Authorized Individual Printed name of Authorized Individual Date

ATTACHMENT I - MIHS-HP PROVIDER INFORMATION FORM

Completion of the Provider Information Form ensures that MIHS-HP has the most current information about you and your practice in our provider database and provider directories.

Full Name (Last, First, MI, Degree) **AHCCCS ID Number**_____ **Date of Birth:**_____ **SSN:**_____	**Group/Corporate Name, if applicable** **Office Manager Name**:_____ **Telephone Number:**_____
Enter Specialty*:* _____ ***Check one:*** _____**PC** _____**Specialist**	
Business Address #1:	**Mailing Address:**
Full Street Address:	**Full Street Address**
City, State, Zip:	**City, State, Zip:**
Telephone w/ Area Code:	**Telephone w/ Area Code:**
Medicare ID Number (UPIN)	
Fax Number:	**Fax Number:**
Tax ID Number (TIN)	

Covering Physicians(s)

Physician Name	Specialty	Telephone Number

THIS IS A TWO-PAGE DOCUMENT
YOU MUST COMPLETE AND SIGN THE SECOND PAGE

Business Address #2:	**Mailing Address:**
Full Street Address:	**Full Street Address**
City, State, Zip:	**City, State, Zip:**
Telephone w/ Area Code:	**Telephone w/ Area Code:**
Fax Number:	**Fax Number:**
Tax ID Number (TIN)	

Covering Physicians(s)

Physician Name	Specialty	Telephone Number

HOSPITAL PRIVILEGES	
1)	**3)**
2)	**4)**

LANGUAGES SPOKEN IN OFFICE	
By Practitioner:	**By Office Staff:**

By signing below, I hereby attest that all information provided is completed and accurate and that I wish to continue participation as a direct contract with MIHS.

Printed Name **Signature** **Date**

ATTACHMENT J - Maricopa Integrated Health System-Health Plan Authorization/Release

All information submitted in this application will be treated by Maricopa Integrated Health System and all agencies receiving this information as confidential and protected under Arizona state statutes.

RELEASE AUTHORIZATION:

For the purpose of evaluating my qualifications and competency for regular biennial appointment/reappointment to the Maricopa Integrated Health System's provider panel, I hereby:

1. Acknowledge that any significant misstatements in or omissions from this application constitute cause for denial of my appointment/reappointment to the provider panel;

2. Signify my willingness to appear for interviews in regard to my application;

3. Authorize Maricopa Integrated Health System – Health Plans, provider panel, their representatives and their agents to consult with my prior associates, insurance carrier(s) and others who may have information bearing on my professional competence, character, health status, ethical qualifications and ability to work cooperatively with others;

4. Consent to the inspection by the Maricopa Integrated Health System – Health Plans, provider panel, their representatives and agents of all documents that may be material to an evaluation of my qualifications and competence that are in the possession of hospitals at which I have or have had privileges or have applied for privileges, insurance companies that have insured me or to whom I have applied for insurance and/or the National Practitioner Data Bank and my documents that may be produced in response to specific inquiries made in furtherance of the credentialing process;

5. Release from liability all representatives and agents of the Maricopa Integrated Health System – Health Plans and chair representative for their acts performed and statements made consistent with this authorization in connection with evaluating and acting upon my appointment/ reappointment application;

6. Release from liability any and all individuals and organizations who provide information consistent with this authorization to the Maricopa Integrated Health System – Health Plans or provider panel or their representatives or agents, concerning my appointment/reappointment application and/or my professional competence, ethics, character and other qualifications for medical staff appointment/reappointment and clinical privileges;

7. Acknowledge that the provisions of Maricopa Integrated Health System – Health Plans relating to confidentiality and release from liability are express conditions to my application for continuation of membership and to my exercise of clinical privileges;

8. Pledge to maintain an ethical practice, to provide for continuous care for my patients, and to refrain from delegating the responsibility for the care of my patients to any practitioner not qualified to undertake that responsibility;

9. Acknowledge that I, as an applicant for provider panel participant membership and/or privileges, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications for membership and clinical privileges and for resolving any doubts about such qualifications;

10. Agree that a photocopy of this agreement shall be as binding as the original when so presented.

This agreement shall remain in full force and effect for a period of two (2) years from date shown below;

11. Agree that I will immediately notify the hospital at least thirty (30) days before any cancellations or termination of my professional malpractice insurance coverage which may occur at any time during my medical staff membership;

12. Acknowledge that if I make any changes in the wording of this printed application, the application will be deemed "incomplete" and will not be considered for appointment/reappointment.

13. Agree that the exclusive remedy for any decision or recommendation made pertaining to the application for appointment/reappointment or in any other peer review proceeding shall be to seek review of the correctness of the decision or recommendation, that no claim for alleged money damages will be brought on account thereof, and that no action at law or in equity will be brought until after all appeal rights available have been exercised and completed.

14. I agree to notify the Maricopa Integrated Health System – Health Plans administrator(s) within ten (10) days of notice of any suit or claims alleging malpractice or malfeasance against me. I further agree to notify the Maricopa Integrated Health System – Health Plans administrator(s) thirty (30) days prior to any change in my malpractice insurance coverage.

All information submitted by me in this application is true to my best knowledge and belief.

_____
Printed Name

_____ _____
Signature Date

ATTACHMENT K: RESPONDENT'S CHECKLIST

Submitted	Document Required	Original
_____	Table of Contents	1
_____	Authorization to Submit Response	1
_____	Letters of Reference	1
_____	List of Office Locations, Phone #, hours	1
_____	Price Acceptance	1
_____	Professional Qualifications: • Arizona Dental License • ADA Board Certification • DEA License • Curriculum Vitae	1
_____	Description of any sanctions	1
_____	Provider Information Form (includes list of hospital privileges, if applicable)	1
_____	Authorization/Release Form	1
_____	Signed Addenda Cover Page(s), if applicable	1
_____	Respondent's Checklist	1

All items must be included in the Respondent's submission in order to be considered responsive to this ROQ.

ATTACHMENT L - Maricopa Integrated Health Systems Quick Reference Grid (Information Only)

	Product Type	Assigned PCP	Prior Authorization	Specialist Referral	Appointment Desk	Member Services	Claims Address	Radiology	Lab	Mental Health	Co-Pay	RX Benefit
Health Select ***(Maricopa County Employee Health Plan)***	Maricopa Integrated Health Systems Employee Benefit Plan	YES	(602) 344-8111	YES	(602) 344-1015 fax 344-1143	(602) 344-8760 (800) 582-8686	MIHS-HP PO Box 20019 Phoenix, AZ 85036 (602) 344-8555	FHC Valley Radiology TMC Radiology	FHC MMC Sonora /Quest Lab Corp	(800) 343-2183 MCC	$5 Office Visit $5 Urgent Care $50 Emergency	FHC $2 generic $5 brand Fry's Food & Drug United Drug $4 generic $10 brand
Maricopa Health Plan ***(MHP)***	AHCCCS Medicaid Plan	YES	(602) 344-8111	YES	(602) 344-1015 fax 344-1143	(602) 344-8760 (800) 582-8686	MIHS-HP PO Box 20019 Phoenix, AZ 85036 (602) 344-8555	FHC Valley Radiology TMC Radiology	MMC FHC Sonora /Quest Lab Corp	Value Options 1-800-564 5465	EPSDT-None Prenatal-None $1 Office Visit	FHC Fry's Food & Drug United Drug No Co-pay
KidsCare	AHCCCS Medicaid Plan	YES	(602) 344-8111	YES	(602) 344-1015 fax 344-1143	(602) 344-8760 (800) 582-8686 Please contact Member Services due to limited benefits.	MIHS-HP PO Box 20019 Phoenix, AZ 85036 (602) 344-8555	FHC Valley Radiology TMC Radiology	MMC FHC Sonora /Quest Lab Corp	Value Options 1-800-564 5465	$0 Office Visit $5 Non Emergency use of the Emergency Room	FHC Fry's Food & Drug United Drug No Co-pay
Maricopa Senior Select Plan ***(MSSP)***	Medicare +Choice	YES	(602) 344-8111	*YES Please Note: Members may self refer for the following services. *Mammography *Pnuemococcal vaccination *Routine and Preventative Health Care Services	(602) 344-1015 fax 344-1143	(602) 344-8760 (800) 582-8686	MIHS-HP PO Box 20019 Phoenix, AZ 85036 (602) 344-8555	FHC Valley Radiology TMC Radiology	MMC FHC Sonora /Quest Lab Corp	(602) 344-8710	$5 Office Visit $5 Urgent Care $10 Emergency	FHC Fry's Food & Drug United Drug $2-$4 generic No limit $5-10 brand $250 month /limit
Maricopa Long Term Care ***(MLTCS)***	Long Term Care	YES	(602) 344-8111	YES	Contact Case Manager	(602) 344-8760 (800) 582-8686	MIHS-HP PO Box 20019 Phoenix, AZ 85036 (602) 344-8555	Valley Radiology TMC Radiology	MMC FHC Sonora /Quest Lab Corp	0-18 yrs Contact Case Manager Title X1X Over 18 GLTC 602-344-5844	NONE	Supplies & DME please contact Case Manager